

**Minutes of the 43rd Meeting
of the
SAMHSA National Advisory Council**

March 12, 2008

**SAMHSA Office Building
1 Choke Cherry Road
Sugar Loaf and Seneca Conference Rooms
Rockville, Maryland**

**Department of Health and Human Services
Substance Abuse and Mental Health Service Administration**

**Substance Abuse and Mental Health Services Administration
43rd Meeting of the SAMHSA National Advisory Council**

Minutes

March 12, 2008

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council convened for its 43rd meeting on March 12, 2008, in the SAMHSA Office Building in Rockville, Maryland. Terry L. Cline, Ph.D., SAMHSA Administrator, and Council member James R. “Duke” Aiona, Jr., co-chaired the meeting.

Council Members Present: James R. “Duke” Aiona, Jr., Marvin C. Alexander, L.M.S.W., George Braunstein, Terry L. Cross, M.S.W., L.C.S.W., A.C.S.W., Judy Cushing, Faye Annette Gary, Ed.D., R.N., Keith N. Humphreys, Ph.D., Thomas A. Kirk, Jr., Ph.D., Kenneth D. Stark (via telephone), Cynthia Wainscott, and Edward K.S. Wang, Psy.D. (see Tab A, Council Roster)

Council Member Absent: Columba Bush

Ex-officio Member Present: Laurent S. Lehmann, M.D., Department of Veterans Affairs

SAMHSA Deputy Administrator: Eric Broderick, D.D.S., M.P.H.

Acting Council Executive Director: Jennifer Fiedelholz, M.P.P.

Council Designated Federal Official: Toian Vaughn, M.S.W.

Non-SAMHSA Federal Staff Present: 4 individuals (see Tab B, Federal Attendees List)

Representatives of the Public Present: 23 individuals representing 20 organizations and the trade press (see Tab B, Public Attendees List)

Welcome and Opening Remarks

SAMHSA Administrator Dr. Terry L. Cline called the Council meeting to order on March 12, 2008, at 9:05 a.m. and welcomed attendees. He introduced Dr. Peter Delany, SAMHSA’s new Director, Office of Applied Studies. Council members introduced themselves.

Ms. Jennifer Fiedelholz, Director, Office of Planning and Performance Measurement Unit, Office of Policy, Planning and Budget, explained that, henceforth, draft minutes of Advisory Council meetings will be forwarded electronically to members for review and comment. Dr. Cline noted the presence at the meeting of representatives of Federal partner agencies and acknowledged their support for the work of SAMHSA and the Council.

Mr. “Duke” Aiona, Council Co-Chair, welcomed members. He suggested that members consider topics, suggestions, and recommendations for the Council roundtable discussion later in the meeting.

Administrator’s Report

Dr. Cline stated that the agency embraces a public health approach in providing a comprehensive continuum of services from prevention to more acute services to recovery and to maintaining recovery. SAMHSA also focuses on integrating mental health with primary health care systems and other practitioners at the Federal, State, and local levels. In trying to impact the agendas and priorities of other stakeholder agencies and organizations that play significant roles in addressing needs related to substance abuse or mental illnesses, SAMHSA is proactively offering technical assistance and expertise to its new partners.

Dr. Cline emphasized the need for moving interventions upstream—concentrating to a greater degree on prevention—while simultaneously continuing SAMHSA’s mission to serve persons with severe mental health and substance abuse problems.

Current national statistics show that 32,000 people on average intentionally kill themselves each year. Of the approximately 700,000 individuals who are homeless on any given night, 20-25 percent would meet criteria for a serious mental illness, and about half that group would have co-occurring alcohol and drug use problems. About 38 percent of the homeless population report problems with alcohol and about 26 percent report problems with other drugs. Depending on the study, 16 to 50 percent of all incarcerated individuals have a mental illness and up to 80 percent have a substance abuse problem. Dr. Cline observed that the cost associated with incarceration, treatment, and such outcomes as recidivism make it good public policy to intervene early to treat people with addictions and mental illnesses.

People with mental illnesses are dying 25 years earlier than the general population, representing a great health discrepancy, as a result of heart disease and complications from diabetes. Lost productivity due to bipolar disorder alone costs employers nationwide \$14.1 billion, and major depressive disorder costs employers \$36.6 billion, which costs are passed on to the public. In the general health care system, about 25 percent of all community hospital stays involve people with a mental illness or substance abuse diagnosis, the majority of whom do not receive specialized care. Dr. Cline pointed out the burden of cost on that system and called into question the effectiveness of these hospital stays as an intervention.

In considering the value of prevention, Dr. Cline reported on the pattern of first-time drug use among adolescents ages 12 to 17. On any given day, thousands of adolescents begin using substances for the very first time; 4,300 adolescents use illicit drugs, 4,000 smoke cigarettes, 3,600 smoke marijuana, and 2,500 misuse prescription drugs. One might expect those young people to continue using substances each day into the future.

SAMHSA recently released State-by-State data that can help States to determine their needs regarding prevention and treatment systems. Dr. Cline highlighted significant substance abuse trends since 2001, including a 24 percent reduction in the overall rate of illicit drugs and a 25

percent drop in marijuana use. Alcohol and cigarette use have declined 15 and 33 percent, respectively, including a reduction in binge drinking. Concern remains about underage drinking, which has proven difficult to impact.

SAMHSA continues its mental health system transformation efforts across the country. The unprecedented Federal Executive Steering Community, whose members include nine Cabinet-level agencies, convenes agency and departmental representatives to focus on behavioral health services. With its new upstream approach, SAMHSA has increased emphasis on children and families. Congress has funded the Linking Action for Unmet Needs in Children's Health (Project Launch) grant program to focus on the age 0 to 8 population. In addition, SAMHSA is strengthening its relationship with the Departments of Defense and Veterans Affairs in the areas of mental health promotion and substance abuse prevention among veterans.

In FY 2009, SAMHSA will initiate the Mental Health Court Initiative and new Mental Health Targeted Capacity Expansion (TCE) grants program that offer States and communities flexibility to identify their own needs, present proposals to SAMHSA, and compete for "customized" grants. The Strategic Prevention Framework (SPF) program, a framework to help States build substance abuse prevention infrastructures, will expand to provide public health-focused guidance in other areas.

SAMHSA is promoting the Surgeon General's "Call to Action on Underage Drinking." SAMHSA also has joined forces with the Office of National Drug Control Policy (ONDCP) on preventing prescription drug misuse. SAMHSA is continuing Screening, Brief Intervention, Referral and Treatment (SBIRT) programs in its effort to move upstream. More than 545,000 SBIRT screenings have taken place nationwide, of which approximately 23 percent required a brief intervention or referral to treatment. Of those who received a brief intervention, 74 percent reported significantly reduced alcohol or drug use, and 48 percent reported no usage. The Access to Recovery (ATR) program surpassed SAMHSA's goals, with 199,000 people served in a voucher-based system that increases the scope of services provided and expands the provider base.

SAMHSA is forging strategic alliances with the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and other Federal partners. The National Registry of Evidence-based Programs and Practices (NREPP) enables the field to review and select evidence-based practices; its flexible standard facilitates community-based practices to reach the field. The SAMHSA Health Information Network (SHIN) website experiences 50,000 hits a month, and Addiction Technology Transfer Centers (ATTCs) help grantees implement evidence-based practices.

SAMHSA's Budget and Legislative Issues: Overview

Center for Substance Abuse Treatment (CSAT). Dr. H. Westley Clark, Director, CSAT, described the CSAT budget process. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Program budget remained stable in FY 2007-08, with a proposed increase for FY 2009 of approximately \$20 million. After two stable years, the proposed budget for Programs of Regional and National Significance (PRNS) related to capacity would decline in

2009 by \$48.5 million and decrease by \$14.5 million for Science and Service grants. In FY 2009, CSAT's total PRNS budget would decrease by \$63 million, and the total CSAT budget, which includes the SAPTBG, would decrease by \$43.1 million. Principles that guided budget decisions for FY 2009 included balancing the budget by FY 2012, no new taxes, emphasis on delivery of direct services, necessity to make hard choices, and funding decisions that involved multiple factors.

Dr. Clark stated that the FY 2008 CSAT appropriation restored approximately \$50 million to a large number of discretionary programs slated for reduction in the FY 2008 request. For specific programs, the FY 2008 budget added funds for tribes and tribal organizations, maintained Minority AIDS funding, and reduced Drug Court and SBIRT funding. The FY 2008 CSAT budget also includes funds for approximately 25 Congressional earmarks. Dr. Clark identified several funding opportunities for FY 2008, including Screening, Brief Intervention, Referral and Treatment (SBIRT) for States, tribes, and medical school residency programs, and TCE for American Indians/Alaskan Natives (AI/AN), for Asian American and Pacific Islanders (AAPI), and TCE Recovery Systems of Care. Grants also will be available under the proposed budget for HIV/AIDS, Criminal Justice Treatment, Treatment Drug Courts, Pregnant and Postpartum Women's (PPW) Residential Treatment, Historically Black Colleges and Universities (HBCU), and Treatment for Homeless.

CSAT's key FY 2008 activities and initiatives include implementation of Cohort II Access to Recovery (ATR) grants; broadened availability of Screening and Brief Intervention (SBI) programs; enhanced treatment services for AI/AN tribes; promotion of recovery support services and recovery-oriented systems of care; addressing methamphetamine treatment needs; promoting HIV rapid testing; participation in an Office of Management and Budget (OMB) Program Assessment Rating Tool (PART) assessment of the Drug Court initiative; finalizing National Outcome Measures (NOMs) and assisting States in developing capacity to report Block Grant performance outcomes; continuing to investigate methadone deaths, promoting voluntary opioid treatment program reporting, and communicating safe dispensing practices to physicians and consumers; developing the substance abuse treatment workforce; and adopting a public health approach to service delivery.

Reflecting the President's budget priorities for FY 2009, CSAT will offer Drug Court treatment grants; implement SBIRT programs in general health settings; and continue to support community- and faith-based programs under ATR. CSAT will maintain funding for the Substance Abuse Block Grant with an additional \$20 million in performance incentives, support direct services over infrastructure, and seek savings in lower-priority programs. Programs with proposed increased funding include ATR, Treatment Drug Courts, SBIRT, and the National Registry of Evidence-based Programs and Practices (NREPP), and level funding would be maintained for the Minority AIDS Program and the SAMHSA Health Information Network (SHIN). Programs slated for reduced funding include Opioid Treatment Programs, TCE General, and Treatment for Homeless.

Key factors for FY 2009 program reductions/elimination include one-time expenditures that need no replication, completed functions/commitments within grants and scrutiny of automatic renewals, programs with purposes addressed elsewhere, underperforming programs and

programs without solid performance measures, and proposed reductions in the past that were not enacted.

CSAT programs proposed to be eliminated in FY 2009 include Co-occurring State Incentive Grants (COSIG), PPW Residential Treatment, Strengthening Treatment Access and Retention, Recovery Community Services Program, Treatment for Children and Families, Minority Fellowship Program grants, Knowledge Application Program, Partners for Recovery, and Recovery Month activities. Proposed FY 2009 funding opportunities include SBIRT, Treatment Drug Courts, and Treatment for Homeless.

Council Discussion

Dr. Keith Humphreys requested clarification on offsets to terminated COSIG grants. Dr. Clark stated that increased emphasis would be placed on SBI in primary care settings and questions about mental health added to the SBIRT portfolio. Ms. Fiedelholz stated that many service grant announcements now require routine screens for co-occurring disorders. Ms. Cynthia Wainscott noted the adverse impact on upstream programs of early termination of PPW grants.

Center for Substance Abuse Prevention (CSAP). Dr. Anna Marsh, Acting Director, CSAP, reviewed CSAP's FY 2009 proposed budget of \$158 million, down \$36 million from 2008. Proposed activities include a new Prevention TCE program. Programs to be maintained at 2008 levels include Fetal Alcohol Syndrome Disorder, HIV/AIDS, NREPP, and SHIN. Programs to be retained at reduced levels include Strategic Prevention Framework State Incentive Grants (SPF SIGs), Lab Certification in the Drug-Free Workplace Program, and the Data Coordination and Consolidation Center (DCCC). Grants to be eliminated are Workplace Youth, Methamphetamine, Sober Truth on Preventing (STOP) Underage Drinking Act, discretionary funding for Centers for the Application of Prevention Technology (CAPT) (some funding would remain under the Block Grant), and the Native American Resource Center.

In illustrating CSAP funding trends since 2005, Dr. Marsh pointed out that although the President's budget cuts Programs of Regional and National Significance (PRNS) funds, Congress historically enacts funding for CSAP programs, including discretionary funds, with little overall reduction.

Proposed new and higher-funded initiatives include \$20 million in the Substance Abuse Prevention and Treatment Block Grant for supplemental performance awards. Funds from grants that end naturally would free \$38.180 million for new SPF SIG grants. Seven million dollars were also identified for a new TCE program for States and local communities.

Dr. Marsh stated that the President's FY 2009 budget would provide 94 percent of CSAP's total FY 2008 funding, with reductions achieved through increased program efficiencies and elimination of duplicative activities. The budget sustains most major CSAP program initiatives and accommodates new and increased initiatives.

Council Discussion

Mr. Marvin Alexander inquired about the process to determine program elimination. Dr. Marsh explained that CSAP presents proposals, which are subject to an iterative process of review and comment by SAMHSA, Department of Health and Human Services (DHHS), and OMB. Ms. Judy Cushing inquired about SPF SIG funding for States that have not yet received funds. Dr. Cline responded that sufficient funds are available to continue existing grants, and that SAMHSA aims to ensure that all States and five of the six territories establish SPF SIGs. Ms. Cushing observed that STOP Act grants would be canceled after only one year. Dr. Cline explained that the funding levels proposed for FY 2009 represent overall reductions but include increases for selected programs.

Center for Mental Health Services (CMHS). Ms. A. Kathryn Power, Director, CMHS, stated that CMHS's proposed FY 2009 budget of \$784 million represents a net decrease of \$126 million from FY 2008 levels. Programs with proposed increases in funding include Children's Mental Health Services and Projects for Assistance in Transition from Homelessness (PATH). The Community Mental Health Block Grant program will continue at current funding levels. Significant programs with decreased budgets from FY 2008 include Protection and Advocacy for Individuals with Mental Illnesses and 22 PRNS programs.

Proposed new categories of funding in FY 2009 include Mental Health TCE and Mental Health Drug Courts. Programs maintained at FY 2008 levels include the Minority AIDS and HIV/AIDS Education programs. Programs with increased funding include the Garrett Lee Smith Suicide Prevention Campus Program, AI/AN Suicide Prevention Initiative, NREPP, and SHIN. Programs with reduced funding include COSIGs, youth violence prevention, trauma-informed services, State and tribal suicide prevention, homelessness prevention, and criminal/juvenile justice. Programs that will end naturally or be eliminated include alternatives to seclusion and restraint, children and family programs, transformation activities, Mental Health SIG grants, Project Launch, older adult programs, and Congressional projects. Ms. Power pointed out that since FY 2005, appropriations historically have exceeded the President's proposed budgets.

CMHS is attending to such policy issues as reauthorization of SAMHSA, scheduled for congressional consideration in 2009; an imminent Federal Communication Commission (FCC) ruling on ownership and operation of toll-free suicide prevention hotlines; mental health parity, with a focus on House passage of the Paul Wellstone Mental Health and Addiction Equity Act; Mentally Ill Offender Treatment and Crime Reduction Act; Community Mental Health Services Improvement Act, which would co-locate primary care services and community mental health settings, and support innovative programs for mental health workforce recruitment and retention; and reauthorization of the Indian Health Care Improvement Act.

Council Discussion

To Ms. Cushing's question about SAMHSA strategies upon an adverse FCC ruling, Ms. Power responded that deliberations are ongoing to deal with that unlikely event. Ms. Wainscott acknowledged Ms. Power's leadership on the hotline issue.

Dr. Thomas Kirk inquired about how the field can communicate the need for a long-term perspective and trend-analysis approach in evaluating outcomes of systemwide, public health-oriented initiatives such as Mental Health Transformation. Dr. Cline acknowledged the vulnerability of such programs and the challenge to demonstrate their effectiveness in the absence of data. He suggested that Council members speak to the ripple effect of transformed mental health services on the health care and other impacted systems, emphasizing the need to deliver services effectively. Dr. Kirk stated that grantees can provide feedback on how grant funds help States derive incrementally better outcomes in terms of return on the investment of new funding. Ms. Power responded to a question from Mr. George Braunstein about the inevitable difficulties in developing consistent performance measurements as State systems undergo transformation of both infrastructure and philosophy. She noted that SPF-SIG measures in terms of community improvement, community penetration, and others may produce learnings in this regard.

Dr. Faye Gary asked how SAMHSA informs grantees about program termination. She stated the need for intellectual, material, and emotional support among grantees to sustain aspects of their programs that have become embedded in the community. She also observed that ending programs early erodes confidence in the mental health system and impedes transformation. Ms. Power responded that SAMHSA personnel communicate proactively with grantees, States, and constituent groups about the budget. In addition, in the interests of sustainability, CMHS takes care to connect affected grantees with other grantees—current and former, same and related programs—by means of learning communities and other approaches, to facilitate creation of materials, substantive community activities, and personal and professional connections.

Dr. Edward Wang suggested that Council members engage in a discussion of activities by which they can promote the transformation agenda. Mr. Terry Cross observed that sacrificing PRNS programs compromises SAMHSA's long-term influence at the State level. He noted that PRNS programs typically do not produce the kinds of data produced in other programs where a large percentage of the budget is allocated to evaluation. Ms. Power acknowledged the difficulty of finding uniform measures across the PRNS programs portfolio.

Council Member Recognition

Dr. Cline recognized the leadership and contributions of Mr. Aiona, whose tenure on the Council was drawing to a close. Mr. Aiona recommended that Council members actively participate in Council-related work.

Eliminating Health Disparities

Dr. Larke Nahme Huang, Senior Advisor on Children, Youth, and Families, SAMHSA, discussed cultural competence and eliminating disparities, a cross-cutting principle in the SAMHSA Matrix of Priorities and the focus of a SAMHSA-wide matrix working group. Dr. Huang highlighted the Agency's cultural competence roadmap and work plan, which focus on internal capacity building: in-services and professional development, Executive Leadership Performance Plans, RFA language to reflect cultural adaptations or practices relevant for special populations, and data gathering. The plan's external projects include the National Network to Eliminate Disparities in Behavioral Health (NNED) and public education campaigns related to mental health and underage drinking.

SAMHSA has conducted census projections on the changing demographics of various population subgroups to determine whether its substance abuse prevention and treatment and mental health programs are poised to meet current and future needs. In addition, SAMHSA has examined if State grants affect populations of color and if giving resources directly to communities might prove more effective. Input on these issues will impact allocation of SAMHSA's resources and workforce training efforts.

Dr. Huang described the NNED, a developing national network of community- and ethnic-based organizations and networks working to eliminate disparities in behavioral health; Knowledge Discovery Centers, which may work with community-based organizations on workforce development, developing research partnerships to evaluate practices, and developing evidence in community-based organization; and a National Facilitation Center to coordinate the NNED.

NNED envisions a condition where all culturally, racially, and ethnically diverse individuals and families live healthy, thriving lives and participate in supportive communities. Its mission is to build a natural network across various stakeholder groups, across sectors, and among culturally diverse groups. Its key assumptions include the need to link "pockets of excellence" in reducing existing disparities nationwide, in terms of outreach and engagement, access to appropriate quality care, early identification, early intervention, treatment and recovery with attention to cultural adaptations to evidence-based practices, and community- and culturally-generated interventions. NNED's infrastructure to date includes a governance structure; operations center; an intranet site to support the work of the governance group and the NNED membership, an Internet site with geomapping and GIS capabilities, a monthly electronic newsletter, training and peer technical assistance, other activities that may be generated by community membership; and a process of membership invitation and recruitment. Current activities include a community-defined evidence project to measure practice effectiveness, a mental health education and anti-stigma campaign for diverse communities, and a similar campaign for prevention of underage drinking in diverse communities.

Mr. David Mineta, Deputy Director, Asian American Recovery Services, San Mateo County, California, explained that his agency and other similar organizations address often extreme health disparities in outreach, engagement, successful treatment outcomes, and retention, especially in diverse communities. Originally founded to serve Asian Americans and Pacific Islanders (AAPI), half of his agency's clients now are non AAPIs, including many Latinos.

Most of the agency's work is moving to evidence-based models. Although NREPP is the preferred site to learn about high-quality services modifiable for AAPI clients, it has been difficult to add community-based, culturally competent programs to that list.

Dr. Kenneth J. Martinez, Board Member, National Latino Behavioral Health Association (NLBHA), and Principal Research Analyst, Technical Assistance Partnership for Children and Families' Mental Health, American Institutes for Research, pointed out that disparities in mental health care are widening between whites and people of color, and that ethnically, racially, and diverse populations experience a greater disability burden from emotional and behavioral disorders than do white populations. He pointed out that evidence-based practices may address quality and accountability of interventions, but when developed without attention to historical, contextual, and transactional considerations and values, they are not culturally appropriate or accurate. For example, consideration of the contextual variable of immigration status and attention to engaging cultural communities in both treatment and research are critical.

Although limited research has been conducted, representatives of ethnic and racial groups are largely missing from efficacy studies in the evidence base. A viable supplement to the academic approach of randomized controlled trials is community-defined evidence, which involves a set of practices that communities have found to yield positive results, as determined by community consensus over time, and which may or may not have been measured empirically.

Dr. Martinez stated that the Community Defined Evidence Project (CDEP) is informed and will be used by the Latino community and other ethnic and racial groups to diffuse knowledge through the NNED, and develop an inventory of community-defined practices used nationwide. Dr. Mareasa Isaacs, Executive Director, National Alliance of Multi-ethnic Behavioral Health Associations (NAMBHA), discussed the NNED National Facilitation Center, operated under the auspices of NAMBHA, which coordinates the voices of the NLBHA, National Asian American Pacific Islander Mental Health Association, National Leadership Council on African American Behavioral Health, and First Nations Behavioral Health Association in eliminating disparities. The National Facilitation Center seeks to build the network starting with community and ethnic-specific organizations.

NNED priority areas have emerged from the NNED membership include identifying strategies for effective community engagement; community capacity building; integration of health and behavioral health; focus on wellness, prevention, and early intervention; identification and dissemination of culturally appropriate practice models; and innovative approaches to education and training in workforce issues.

Panel Discussion

Mr. Alexander suggested that SAMHSA find ways to support the spirit of the Minority Fellowship Program. Mr. Cross applauded SAMHSA's efforts to create a framework for eliminating disparities and to focus on the challenges posed by using evidence-based practices in communities of color, rural communities, and community-based programs with strong family involvement.

Dr. Gary observed the need to consider a range of models, theories, interventions, and approaches, including workforce training, to serve the needs of minority populations with long-term histories in the United States as well as those of populations that have arrived more recently. She also observed the need to reform a national research system that impedes development of effective practices for people of color because few principal investigators, subjects, and peer reviewers of color participate in that system.

Mr. Braunstein emphasized the role of community centers as access points to behavioral health care for diverse populations and the need to integrate mental health and substance abuse services into general health systems.

Dr. Wang suggested the need to link State offices dedicated to eliminating disparities with NNED, SAMHSA, and the National Association of State Mental Health Program Directors (NASMHPD). He noted the shift from *discussions* of “why cultural competence and eliminating disparities?” to *solutions* that focus on “how” to eliminate mental health and health disparities. In light of stringent budget realities, Dr. Wang stated the need for concrete, realistic, small steps grounded in community-determined priorities.

Mr. Cross expressed concern about programs represented in NREPP as relevant to Native populations when details reveal that only 3 percent of the evaluation sample was Native American. Mr. Mineta suggested that user-friendliness would be improved if information on sample size were posted on programs’ initial Web page. He asserted that ethnic community-based organizations and networks will solve the health disparity, but difficult economic circumstances will impede that effort, making support for the ethnic organizations essential.

Dr. Huang invited Council members to discuss the issues raised at the Council meeting. She noted the difficulties community-based organizations face in securing funding to serve special constituencies, particularly when funds hinge on implementing evidence-based practices. She stated that the novel NNED approach is designed to (1) link culturally diverse communities, identify exemplary community-based organizations that are providing effective interventions to their communities and create a multiplier effect by disseminating these exemplary community-determined practices through peer trainings and TA, and facilitated learning collaborative; and (2) to build partnerships between community-based organizations and researchers and evaluators to build the evidence for these community-based practices.

Mr. Aiona explained that Hawaii’s prevention infrastructure and transformation grants have produced results that can serve as a model for other States; Hawaii leads the country in diversity.

SAMHSA’s Data Strategy

Dr. Eric Broderick, Deputy Administrator, SAMHSA, highlighted the development of the “SAMHSA Data Strategy,” a plan to provide timely, comprehensive, relevant, and accurate data to guide and improve policy making, program development, and performance monitoring. The strategy’s three goals are accompanied by objectives and milestones to assess progress over time. SAMHSA currently is conducting a gap analysis to address areas that need attention.

Goal 1 relates to national epidemiological data on mental health and substance abuse disorders, information about the provider pool, and financing issues. Milestones include assessing SAMHSA's national data needs, establishing a substance abuse prevention location system, accessing data on mental illnesses and substance abuse disorders of inmates in partnership with other agencies, publishing nationally representative data on adults with serious mental illnesses and/or substance abuse and the services they need, and obtaining data on persons who use opioid treatment. Consideration was accorded to rectifying disparities in data collection by adding mental health components to existing substance abuse surveys.

Goal 2 addresses issues related to demonstrating performance of the Block Grant and discretionary grant programs. Milestones center on NOMs development, need to demonstrate program effectiveness, and capacity to remediate programs, if necessary.

Goal 3 relates to promoting use of interoperable electronic health records and health information technology. Objectives and milestones focus on developing standards related to mental health and substance abuse, inclusion of mental health and substance abuse standards into the development of an electronic medical health record for the medical system at large, encouragement of States to adopt that capacity for use by substance abuse and mental health providers, and increasing the number of States that use interoperable systems.

SAMHSA has shared the data strategy with its constituents in the process of developing a 2-year action plan. Dr. Broderick solicited input from Council members on gaps in the plan and how to address them.

Council Discussion

Ms. Wainscott stated that disconnects between government systems pose a serious barrier to collecting data about people in the public mental health system served also by other systems, and to securing accurate, basic information on clients and reimbursement for services. She suggested using Block Grant funds as an incentive for States to provide data and exerting national leadership to encourage data sharing among agencies. Dr. Broderick noted that access to Block Grant funds serves as an incentive to change behavior in reporting on NOMs, adding that SAMHSA is developing a contract to make information on financing needs available prospectively. He noted that partnerships and collaboration are fundamental aspects of the data strategy; for example, SAMHSA now provides technical assistance to the Department of Justice to add mental health questions to surveys of criminal justice and victims populations, and a meeting is set with CDC Director Julie Gerberding to discuss the scope of CDC's data collection. Ms. Power stated that CMHS is working with mental health and Medicaid staff in several States to determine common data platforms that will facilitate information sharing. Ms. Cushing suggested the need to gather data from such untapped populations as homeless youth and ethnic populations.

Mr. Braunstein applauded SAMHSA's data strategy and attention to NOMs. He suggested working with jurisdictions in order to derive knowledge and improve performance, rather than imposing penalties for not submitting data. He stated that his and other agencies are purchasing software to implement electronic health records, trusting that it will interoperate with other

systems; he observed that the process to determine criteria has been slow. Dr. Broderick acknowledged the time required to develop standards and the gamble in acquiring technology before standards are set and noted that compatibility with any known software is a criterion in the ongoing standards process. Ms. Power observed that although the behavioral health field has not participated in discussions on electronic health records, it is hoped that behavioral health records will be fully incorporated into medical records.

Dr. Kirk stated that heads of Connecticut's Medicaid, Labor, Public Health, Developmental Services, and other agencies discussed how interoperability, realignment, and integration can result in better care and dollars better spent. He asserted that making the business case to fellow commissioners can result in massive savings across systems.

Mr. Cross inquired about how SAMHSA evaluates its discretionary programs' performance. Mr. Richard Kopanda, Deputy Director, CSAT, stated that in the past SAMHSA has monitored outputs rather than outcomes. NOMs made it possible to focus on performance, and the next priority is positive performance incentives. SAMHSA now works with States to establish reporting systems under the Block Grant. Ms. Power stated that SAMHSA has recently focused on increasing its investment in epidemiological data related to mental health. She emphasized the need to access data resources available from other agencies and to explore adding questions to important existing surveys. She pointed out that NOMs will incorporate more recovery-focused items over time and that CMHS's Transformation Accountability (TRAC) system will focus on prevalence and surveillance data coupled with program assessment data. Dr. Marsh explained that CSAP staff are discussing how to improve NOMs for the Block Grant and the SPF SIG program. It is necessary in prevention to take into account the target population or entire community—but NOMs require attention to cost-effectiveness.

Dr. Gary inquired if SAMHSA's data strategy addresses technology use to promote health literacy and whether families and consumers can access basic primary-care information about themselves necessary for their own self-care. Dr. Marsh responded that SAMHSA is working with DHHS on its personalized health care record initiative, which focuses on personal health records to which individuals would have access and which would be incorporated into general health care, consonant with the data strategy's third goal.

SAMHSA's Tribal Agenda: Overview

As background to a discussion of SAMHSA's new tribal consultation policy, Dr. Broderick presented an overview of SAMHSA's tribal agenda. Prior to 2005, questions arose continuously about tribes' eligibility to receive discretionary funding. In response, SAMHSA issued a policy decision making Tribes and tribal organizations eligible to compete for all SAMHSA discretionary grants.

SAMHSA recently revised its tribal consultation policy, which guides actions expected to affect Indian tribes significantly. Signed by Dr. Cline in 2007, the policy established a Tribal Technical Advisory Committee to advise the Administrator on matters of substance abuse and mental health as they apply to American Indian and Alaska Native communities. This group of elected Tribal officials from 12 regions of the country, plus representatives of the National

Indian Health Board and the National Congress of American Indians, met for the first time in February 2008.

Tribes have pointed out that the nature of the grantee process creates difficulties for tribes. With one exception, Tribes are ineligible for Block Grants, and while some States deal openly with Tribes and share their resources, other States do not; SAMHSA seeks opportunities to foster collaboration and cooperative agreements between States and Tribes regarding Block Grant resources. Tribes' capacity to compete for and administer discretionary grants falls along a continuum, and SAMHSA recently engaged Tribes to provide the agency with technical assistance on improving grant structure and the content of program announcements to make competition for grants easier for all applicants. In addition, in partnership with the Indian Health Service (IHS), Bureau of Indian Affairs, Small Business Administration, and the Departments of Justice and Housing and Urban Development, SAMHSA offers regional technical assistance workshops on grant writing and grant administration. This partnership also offers tribal leaders a consultation forum. In addition, DHHS sponsors regional consultation sessions and an annual budget orientation session.

Ms. Verné (Qaanaaq) Boerner, Administrative Officer, Northwest Portland Area Indian Health Board, explained that her organization's membership includes the 43 federally recognized tribes in Washington, Idaho, and Oregon. The Board's work is grounded in tribal sovereignty as well as by personal and family experiences. Ms. Boerner began her presentation on her participation in the revision of SAMHSA's consultation policy by telling her personal story and honoring her family members, past and future, in the traditional Alaskan Native way.

Ms. Boerner, a member of the Technical Team Workgroup, attributed the success of the consultation policy/revision process to the commitment and passion of both tribal and Federal Government representatives to improve coordination of SAMHSA's services to tribal communities. The process incorporated an opportunity for tribes to review and comment on an initial draft policy prior to convening the workgroup; at the first meeting participants developed a new draft informed by the HHS policy. SAMHSA officials acceded to the tribal representatives' position that Workgroup activities were not to be considered tribal consultation. SAMHSA submitted the new draft for internal review, a process that went unexpectedly well from the tribal perspective. In October 2006, SAMHSA sent the draft policy to 560 federally recognized tribes, plus national and regional tribal organizations, for comment. The Cherokee Nation and the United South and Eastern Tribes submitted comments, and the Technical Team Workgroup made final edits to the draft that were then approved by the DHHS general counsel. In March 2007, Dr. Cline signed the new policy. Ms. Boerner acknowledged the contributions and spirit of all participants in the process.

Council Discussion

Dr. Humphreys suggested ensuring that the policy is followed, and that people feel it is followed, as a worthwhile next step. Dr. Broderick stated that SAMHSA senior leaders plan in 2008 to visit 20 Indian communities and interact with the people where they live. Mr. Cross lauded SAMHSA for recognizing the government-to-government relationship with Indian tribes and for its important leadership across Federal government agencies. He noted that in most parts of

Indian Country, tribes are the only providers of services for children and families and for people who need mental health services, a dramatic shift from 1968 when the Bureau of Indian Affairs controlled nearly all aspects of Indian life. In the last 20 years, tribes increasingly have taken responsibility for their own services and are making substantial progress. One aspect of progress is dialogue with tribal elders on the concept of community-defined evidence.

Mr. Kopanda pointed out that more tribes are competing successfully for discretionary grants in treatment programs, due in part to their increased willingness to partner with other tribes or with CSAT's ATTC program.

Dr. Broderick stated that to the extent that SAMHSA can provide leadership and address mental health and substance abuse needs in Indian Country and elsewhere, it will do so. SAMHSA resources to tribes have increased by 30 percent between 2006 and 2007, an indicator of progress despite the small amount of funds involved.

Council Roundtable Discussion

Dr. Broderick announced that work is underway to develop the next decade of national health promotion objectives. The Web site www.healthypeople.gov posts information on a series of six regional meetings on Healthy People 2020. Ms. Fiedelholz noted that attendance at these meetings represents an opportunity to influence policy.

Council members developed and consensus was reached on the following draft recommendations, which are to be wordsmithed, approved electronically, and submitted to the SAMHSA Administrator:

1. The Council recommended that its members develop a statement of support for SAMHSA's progressive initiatives that have the capacity to make systemic change, including the SBIRT model (which should be expanded to screen and intervene for mental health problems), Access to Recovery (expanded to include treatment modalities beyond traditional evidence-based practices to demonstrate evidence of their success), Seclusion and Restraint SIGs, the Minority Fellowship Program, other cultural competence programming including NNED, and STOP Act programming to eliminate underage drinking.
2. The Council recommended that SAMHSA require grantees that receive discretionary funding to demonstrate how they use the funds to provide services in a manner that reflects change in the way they serve their customers.
3. Expressing concern that research studies intended to guide service provision (e.g., the evidence-based practices listed in NREPP) typically do not include adequate representation of diverse populations, the Council recommended that SAMHSA enter into a sustained dialogue with the National Institute on Mental Health, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism to ensure that the research they support includes the diverse demographic groups to which their research ought to generalize. The Council likewise recommended that the NREPP database undergo a critical review (1) to ensure that services are not prematurely rated

- “effective” for demographic groups that are inadequately represented in the evidence base and (2) to examine inclusion in NREPP of a broader range of evidence typology.
4. Reflecting members’ shared belief that a culturally and ethnically diverse services and research workforce is essential to promote mental health, reduce substance use, and eliminate health disparities, the Council recommended that SAMHSA collaborate with the National Institutes of Health and other Federal agencies to ensure that all research projects they support include subjects who are members of ethnic minority groups. Significantly, it was recommended that the research also include principal and co-principal investigators who are ethnic minorities and who participate in the creation and dissemination of outcomes. In addition, research in services for mental health and substance abuse use disorders should include ethnic minority communities at all phases of shaping research design and program development—including conceptual, methodological, and analytical aspects of the program, and dissemination of outcomes.
 5. Recognizing the important roles of consumers, youth, and families in assisting SAMHSA fulfill its vision of “a life in the community for everyone,” the Council recommended that SAMHSA continue to invest in the voice and choice of these constituents and continue to support venues where these voices will be created and heard.
 6. The Council recommended that SAMHSA support a sustained, intense focus on health promotion, prevention of mental health and substance use conditions, and early intervention structures and strategies through significant investment and collaboration with the public and private sectors for populations throughout the lifespan.

Upcoming Meetings

Mr. Aiona stated that Ms. Toian Vaughn will coordinate dates for the September 2008 and March 2009 Council meetings. Dr. Gary, seconded by Ms. Wainscott, suggested that the Council meet at grantee sites, perhaps at an Indian reservation. Dr. Broderick suggested collaborating with SAMHSA’s Tribal Advisory Committee on possible meeting sites. Ms. Vaughn responded to a question from Ms. Cushing that, typically, the Council meets semi-annually. Dr. Wang suggested that the Council focus at its next meeting on the issues raised in its new recommendations. Mr. Braunstein suggested holding two work sessions in Washington plus a third onsite meeting. Ms. Vaughn clarified that onsite meetings typically involve a business session the first day and a site visit on the second.

Public Comment

Ms. Sandra Spencer, Executive Director, National Federation of Families for Children’s Mental Health, urged creativity in supporting the organizations that do the work underwritten by the Statewide Family Network Grants slated to be cut from the proposed FY 2009 budget. She asserted that family and youth involvement has contributed to the success of the CMHS Community-Based Systems of Care initiative and urged the Council to focus on its recommendation to ensure that the youth and family voice is sustained.

Mr. Paul Pisano, Vice President, Industry Affairs, National Beer Wholesalers Association, stated that the public health community and the beer industry share a common interest in supporting the STOP Act to fight underage drinking. In addition to providing a funding stream, language in the

bill addresses the role of States and the 21st Amendment. Mr. Pisano also noted his association's support for SAMHSA as chair of the Federal Inter-Agency Coordinating Committee on Preventing Underage Drinking that coordinates issues related to underage drinking, and stated that the association will continue its efforts to restore STOP Act funding.

Closing Remarks and Adjournment

Mr. Aiona and Dr. Broderick thanked Council members for their contributions. The meeting adjourned at 4:25 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

5/16/08
Date

/s/
Daryl M. Kade
Executive Director, SAMHSA National Advisory Council, and Associate Administrator for Policy, Planning and Budget, SAMHSA

Minutes will be formally considered by the SAMHSA National Advisory Council at its next meeting, and any corrections or notations will be incorporated in the minutes of that meeting.

Attachments:

Tab A – Roster of Members

Tab B – Attendees

Substance Abuse and Mental Health Services Administration
SAMHSA NATIONAL ADVISORY COUNCIL
Roster of Members

CHAIRPERSON

Terry L. Cline, Ph.D.

Chair/Administrator

Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 8-1065
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Executive Director, SAMHSA National
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DESIGNATED FEDERAL OFFICIAL

Toian Vaughn, M.S.W.

Public Health Analyst
SAMHSA National Advisory Council
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MEMBERS

Mr. James R. Aiona, Jr. (08)

Lieutenant Governor, Executive
Chamber, Hawaii State Capitol
Honolulu, HI

Mr. Marvin C. Alexander, L.M.S.W. (10)

Youth Coordinator
Mid-South Health Systems, Inc.,
A.C.T.I.O.N for Kids Project
Jonesboro, AR

Mr. George Braunstein (11)

Executive Director
Chesterfield County Community
Services Board
Richmond, VA

Ms. Columba Bush (08)

Former First Lady of Florida
Coral Gables, FL

Mr. Terry L. Cross, M.S.W., L.C.S.W., A.C.S.W. (11)

Executive Director
National Indian Child Welfare
Association, Inc.
Portland, OR

Ms. Judy Cushing (10)

President and C.E.O. Oregon Partnership
Lake Oswego, OR

Faye Annette Gary, Ed.D., RN (09)

Professor
Case Western Reserve University,
Frances Payne Bolton School of Nursing
Cleveland, OH

Keith N. Humphreys, Ph.D. (11)

Associate Professor
Stanford University School of Medicine
Department of Psychiatry
Stanford, CA

Thomas A. Kirk, Jr., Ph.D. (09)

Commissioner
Department of Mental Health and
Addiction Services
Hartford, CT

Mr. Kenneth D. Stark (08)

Department of Social and Health Services
Director—Transformation Grant Division
Olympia, WA

Ms. Cynthia A. Wainscott (11)

Former C.E.O. and President of Mental
Health America
Cartersville, GA

Edward K.S. Wang, Psy.D. (10)
Director, Department of Mental Health,
Massachusetts
Office of Multicultural Affairs
Boston, MA

EX OFFICIO MEMBERS

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Chief Consultant for Mental Health
Department of Veterans Affairs
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Washington, DC 20420

SAMHSA National Advisory Council
March 11-12, 2008

4 Federal Attendees

Administration on Aging – Lori Gerhard
Food and Drug Administration – Celia Winchell
Indian Health Services – Jim Stone
National Institute of Mental Health – David Chambers

23 Attendees Representing Constituents Groups

American Academy of Child and Adolescent Psychiatry – Elizabeth Rorick
American Association for Marriage and Family Therapy – Brian Rasmussen and Tracy Todd
American Psychological Association – Daniel Dawes
Association of Lesbian, Gay, Bisexual, and Transgender Addiction Professionals and Their
Allies – Penelope Ziegler
CD Publications – Laura Ainsley
DB Consulting Group – Patrick Zickler
Entertainment Industries Council – Kim Rymsha
ICF International – Patrick Coleman and Susanne Polkowske
IQ Solutions – Meredith Pond
Latin American Youth Center, Inc. – Natalie Williams
National Alliance of State and Territorial AIDS Directors – Connie Jorstad and Sung Choi
National Association of County Behavioral Health and Developmental Disabilities Directors –
Ellen Witman
National Association of Community Health Centers – Michael Lardiere
National Association of State Alcohol and Drug Abuse Directors – Robert Morrison
National Association of State Mental Health Program Directors – Elizabeth Prewitt
National Council on Problem Gambling – Keith Whyte
National Federation of Families for Children’s Mental Health – Sandra Spencer
National Beer Wholesalers Association – Paul Pisano
Public Policy and National Affairs – Carol Colleran
U.S. Medicine – Stephen Spotswood