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Department of Health and Human Services
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
(SAMHSA)

49th Meeting
SAMHSA National Advisory Council

8:35 a.m.
Wednesday, March 30, 2011

1 Choke Cherry Road
Rockville, Maryland 20857

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P R O C E E D I N G S

MS. PAMELA S. HYDE: All right, good morning. Good morning. Hello. How is everyone? How are everyone? How is everyone? I'm only half awake, haven't had this full cup of coffee yet, but have already made 16 decisions.

[Laughter.]

MALE SPEAKER: --

MS. PAMELA S. HYDE: I'm sure that's true. Yes, we're going to let -- well, we'll do some part of this formality formally, and then we don't yet quite have a quorum. We need to wait for one person to arrive before we can do business. But we've got things to do.

So, Toian?

MS. TOIAN VAUGHN: Good morning. I'll just make this very quick. Welcome to SAMHSA's, I think it's the, 49th meeting of the SAMHSA National Advisory Council. We are looking forward to a great day. And I will now call the meeting to order and turn the meeting over to Ms. Hyde.

MS. PAMELA S. HYDE: And we do have people on the phone, I believe. Is that correct? Okay, so we do have

1 people on the phones, so that means that you have to use the
2 microphones. I think, actually, that's helpful, even if
3 there aren't people on the phone.

4 And let's see. I want the record to reflect that we
5 don't yet have chocolate. But I have a ton of it upstairs,
6 so we'll make sure at the break we get some down here for
7 you. That was a request from Stephanie. So I'll get it.

8 MS. STEPHANIE LAMELLE: Thank you, Pam.

9 MS. PAMELA S. HYDE: You're welcome.

10 So we can't do the minutes and things of that nature
11 just yet until we get a quorum. But you do have the minutes
12 in front of you. And this is minutes from last meeting,
13 which was last August. Hopefully you got all those in the
14 mail and e-mail and various things and you've had a chance
15 to look at them.

16 So can we go ahead, Toian, and have any changes that
17 anybody wants to make and then just hold the actual vote?
18 We can do that, can't we?

19 MS. TOIAN VAUGHN: I would think we should wait for --

20 MS. PAMELA S. HYDE: We should wait until we get a
21 quorum?

22 MS. TOIAN VAUGHN: Uh-huh.

1 MS. PAMELA S. HYDE: All right. Okay. All right, so
2 hold that. We'll come back to that in a minute. And then
3 the other thing you have in front of you is highlights from
4 yesterday. And we do want to spend just a little bit of
5 time talking about that. So we'll go ahead and get that
6 started even before we have a quorum to have a formal
7 business meeting.

8 But let's, one more time, introduce each other or make
9 sure that we know who's here. And welcome to all of you in
10 the audience. We have some folks from our Women's Advisory
11 Committee sitting in this morning, so that's terrific. And
12 perhaps from some of our other advisory committees that are
13 waiting for the other ones to start this afternoon.

14 I will tell you that Kana Enomoto is functioning today.
15 But she got pulled to go to the Tribal Advisory Committee,
16 so she's over there. We have things going on all over the
17 city of Rockville today. So she's over there. I actually
18 don't know if she's going to make it back over here or not.
19 But if any of you have not yet met Kana, you should do that
20 at some point. And she will be with the Women's Advisory
21 Council this afternoon.

22 We're going to go today until about noon, I believe it

1 is. And at that point, I'm going to run over to the Women's
2 Advisory Committee for a short period of time and then spend
3 a little time with the Tribal Technical Advisory Committee.
4 That committee has a lot to do. It's kind of been
5 restructured because those are actually tribal leaders.

6 So if tribal leaders don't get reelected or have some
7 situation in which they are no longer a tribal leader -- if
8 their term expires or whatever -- and some tribes have
9 tribal leaders for life, and others don't. So we already
10 had three or four empty positions on that one. And then, I
11 think, four folks either didn't get reelected, or their
12 terms ended. So we had quite a few empty positions that we
13 were trying to fill. And some of them are still not filled.
14 But nevertheless, it's a fairly new group.

15 And you all met some of them yesterday. And so, I'll
16 be spending some time with them this afternoon, not only
17 getting to know them, but also talking about the behavioral
18 health tribal prevention grant proposal we need to start the
19 consultations now about the formula and how we might
20 distribute those dollars, which, if you think about it for
21 more than about two minutes, you'll realize how complicated
22 that could get. So we'll be spending some time with them

1 this afternoon about that.

2 So that's us. That's what I'm doing today. Those of
3 you who are actually on this council, if you -- once we get
4 done at noon, if you don't have planes that take you
5 somewhere else, you might want to go sit in on some of the
6 other councils, if you're interested. The Women's Council
7 is meeting at the Hilton. Is that correct, guys?

8 FEMALE SPEAKER: They're next door.

9 MS. PAMELA S. HYDE: Oh, they're here? They're here in
10 this building. And the tribal one is meeting in the
11 Sheraton, which is literally a walk from here or a taxi,
12 whichever you prefer. But you can see it. You can walk
13 there. So if you have any interest in any one of those,
14 you're welcome to participate and listen and sit in those.

15 All right, so let's do introductions. I think you know
16 by now that I'm Pam Hyde, the Administrator of SAMHSA.

17 MS. TOIAN VAUGHN: I'm Toian Vaughn, the designated
18 federal official for the SAMHSA National Advisory Council.

19 MS. JORIELLE BROWN: Good morning, everyone. I'm
20 Jorielle Brown. I serve as the special assistant to the
21 administrator.

22 MR. ARTURO GONZALES: Good morning, everyone. Buenos

1 dias. I'm Arturo Gonzales from New Mexico on the Advisory
2 Council.

3 And, Pam, I sure like your earrings. And they're very
4 New Mexican.

5 MS. PAMELA S. HYDE: Yeah, a little New Mexico today.

6 MR. ARTURO GONZALES: A little New Mexican, yeah.

7 MR. MARK WEBER: Good morning. Mark Weber, Director of
8 Communications.

9 MS. STEPHANIE LEMELLE: Stephanie LeMelle, Co-Director
10 of Public Psychiatry Education at Columbia and New York
11 State Psychiatric Institute.

12 MS. FRAN HARDING: Fran Harding, Director for the
13 Center of Substance Abuse Prevention here at SAMHSA.

14 MR. WESTLEY CLARK: Wes Clark, the Director of the
15 Center for Substance Abuse Treatment here at SAMHSA.

16 MS. CYNTHIA WAINSCOTT: Cynthia Waincott from Atlanta,
17 Georgia. And I would like to say a special thank you to
18 Toian and many members of the staff who jumped to and helped
19 me get here with a broken leg. They really performed some
20 amazing things to just sort of make it happen. Thanks.

21 MR. LARRY LEHMAN: Larry Lehman representing Department
22 of Veterans Affairs.

1 MR. PETER DELANY: Pete Delany, Director of Center for
2 Behavioral Health Statistics and Quality. This is too much.
3 We've got to come up with a short --

4 MR. DONALD ROSEN: Don Rosen. I'm Psychiatry Residency
5 Training Director at Oregon Health and Sciences.

6 MS. FLO STEIN: Flo Stein from the North Carolina
7 Division of Mental Health Developmental Disabilities and
8 Substance Abuse Services. And Toian said I could do a one-
9 second advertisement.

10 In your folder, we've put a copy of this report,
11 although yours is not in color, and a copy of this C.D.
12 This is a 17-minute C.D. with great production values about
13 three consumers in North Carolina who were recipients of
14 services that included an evidence-based practice. And we
15 have been promoting evidence-based practice. Kana has
16 helped us in previous years with what we're doing. And we
17 wanted to tell the story from a consumer point of view about
18 how it was working for them. So if you get a chance to look
19 at it later.

20 MS. PAMELA S. HYDE: Great. Thank you.

21 MS. A. KATHRYN POWER: Good morning. Kathryn Power,
22 Director of the Center for Mental Health Services at SAMHSA.

1 MS. KANA ENOMOTO: Good morning. Kana Enomoto, the
2 Director of Office of Policy Planning and Innovation. I'm
3 sorry I missed you yesterday. And I'm fully medicated on
4 over-the-counter medications, doing better.

5 MS. PAMELA S. HYDE: We mentioned you several times.
6 Most of these people know you, but there are some others who
7 probably still want to meet you.

8 All right. Thanks. We do have word from a couple of
9 people. Terry is on his way. And let's see. The other
10 person who's on their way is Hortensia. So we will have a
11 couple more council members. Are there any others coming
12 that we're aware of? Those two?

13 FEMALE SPEAKER: --

14 MS. PAMELA S. HYDE: Okay. And those two will give us
15 a quorum. So we'll do the business when we get to -- when
16 they get here.

17 Let me just take a minute. I should have done this
18 yesterday. I mentioned a couple of people yesterday, but I
19 want to run down the whole list. These kind of meetings,
20 especially this sort of massive multi-council meeting really
21 can't happen without tons of staff support. So just for the
22 record, I want to be clear about who helped us. I'm just

1 going to do first names here. But Toian, Nevine, Patricia,
2 Cynthia, Michael, Sheila, Josephine, Julie, Gilbert. And
3 then from our contractors: Katie, Joss, Theresa, Rachel,
4 Iesha, Beverly and a whole crew behind them. So thanks a
5 ton for all the work yesterday for all of you. They do a
6 terrific job and make this come off.

7 And yesterday was really good, I think. It was very
8 much of an interactive discussion. And I really appreciated
9 the cross-perspectives from the different advisory
10 committees. And that's exactly what we were trying to
11 accomplish. So that was good. And there was a fairly high
12 number of new people in the room, so I think they got a real
13 flavor of a lot of different stuff.

14 And yet, at the same time, as I was listening to just
15 the comments, I realized that as much as we gave you
16 yesterday, and it was a lot, there was still a whole bunch
17 of stuff that we didn't share with you yesterday. So people
18 didn't see the whole in some ways. So in some cases, some
19 of the things people had concerns that we were not
20 addressing or hadn't been touched or whatever is because we
21 didn't present all of everything, which we would have been
22 there probably until midnight if we'd have done that. So

1 nevertheless, I want to thank all of you for doing that.

2 You as a Council really represent the whole. I mean,
3 we really do ask you to carry for us and with us the sense
4 of the whole of the agency. So hopefully it was helpful to
5 you as well. And I do want to just have some time to talk
6 about that.

7 And actually, Kana, I'll give you a minute if you want
8 to because we kind of filled in for you yesterday. And I
9 don't know if we did it justice. But I don't know if you
10 want to say a word or two. Or do you want to --

11 MS. KANA ENOMOTO: About?

12 MS. PAMELA S. HYDE: About anything. We did
13 introductions. We had a time for you to talk about the
14 S.I.'s paper and about OPPI and stuff. And we kind of
15 filled in. But I don't know that we did the best job about
16 that.

17 MS. KANA ENOMOTO: Well, about OPPI, I had done the --
18 I think we did a phone briefing for many of you on the S.I.
19 paper. And so, we're very excited to have that out. And I
20 think it's a deep document that we're using. And it's
21 really permeating all of our work. At one point, someone
22 said, we'll we should stop doing anything that doesn't align

1 with one of the strategic initiatives. And I said, well,
2 we've actually already done that. Like, we went through
3 every single thing. And essentially, the entire portfolio
4 now relates to the strategic priorities that the
5 administrator and SAMHSA have set.

6 With respect to the role of the Office of Policy
7 Planning and Innovation, I think we have a great opportunity
8 to have an office within SAMHSA whose sole objective is
9 really to ensure that the policy directions of the agency
10 are achieved. Before, I think that responsibility has been
11 scattered or diffused across many people and without anyone
12 sort of having the full grasp of what was happening across
13 the agency or the ability to sort of make everything line up
14 together.

15 And I think with the Office of Policy Planning and
16 Innovation being very close with the administrator's office,
17 we have the ability to look across the different entities
18 within SAMHSA to look across our strategic partnerships
19 outside of SAMHSA and through three core functions, through
20 policy liaison, policy coordination and then policy
21 innovation ensure, that we're driving toward a common vision
22 and that all the parts that we have are really coming to

1 bear on achieving that vision. So there's quite a bit of
2 work to do ahead. And we haven't really gotten all the
3 parts together.

4 But as we're doing that process, we've gotten a lot of
5 good feedback from folks. I look forward to receiving more
6 feedback and some good ideas from the council members as
7 well as our stakeholders on what it is that we need to keep
8 an eye on and how we can better serve everyone in
9 understanding what the policy priorities are for SAMHSA and
10 the field.

11 MS. PAMELA S. HYDE: Well, good.

12 Any questions for Kana about that?

13 Okay. Let me remind the council members that we -- I
14 think we're sort of fully set up, although a new office
15 springs up daily, in part because we're asked to do that or
16 in part because we think it's a good idea. So let me just
17 run through the structure right at the moment. We don't
18 have an org. chart in front of you, but we now have four
19 centers. And you'll find us slipping from time to time and
20 talking about three because we used to have three.

21 Now we've got four centers, so we have the three
22 programmatic centers, the Center for Mental Health Services,

1 Center for Substance Abuse Treatment, Center for Substance
2 Abuse Prevention. And we also have the Center for
3 Behavioral Health Statistics and Quality, which is -- I
4 think I did that better than you, Pete. Rolled off the
5 tongue.

6 MR. PETER DELANY: I'm drinking decaf.

7 [Laughter.]

8 MS. PAMELA S. HYDE: At any rate, that center we were
9 really trying to staff up and think about its role in
10 overarching data issues and performance and quality issues.
11 Then we have now seven offices. We have an Office of the
12 Administrator, but the only people left in it are me and
13 Rick, one other person, I think. Anyway, there's three or
14 four of us in the Office of the Administrator.

15 There's OPPI, the Office of Policy Planning and
16 Innovation, Office of Financial Resources, which Daryl
17 Kade's the head of. She was here yesterday. Her office has
18 taken on more than it used to. It used to have budget and
19 other things in it, but it now also has contract and grants
20 management stuff in it.

21 And then we have the Office of Management and
22 Technology, which we refer to as OMT0. And that's headed up

1 by Elaine Perry. And then we have the Office of Indian
2 Alcohol and Substance Abuse, which was in OPPI, but we've
3 moved it to the Center for Substance Abuse Prevention into
4 to Fran's shop because it aligns with a lot of that work.
5 And that came from -- if you remember, Sheila's presentation
6 yesterday. It comes from the Tribal Law and Order Act. So
7 that's a relatively new office.

8 Let's see. I have to count them to make sure I did it.
9 Office of Communications, which is headed by Mark, and then
10 the Office of Behavioral Health Equity, headed by Lark
11 Huang, whom you're going to hear from a little bit later
12 today. So there was a fair amount from this group about the
13 interest in how we were approaching disparities. So we're
14 going to spend some time this morning talking explicitly
15 about that. And you've heard bits and pieces of it from
16 yesterday, but Lark's prepared to sort of walk you through
17 that in a more explicit way.

18 So I think I got all the offices. Is that seven of
19 them? Did I get all seven of them? Every time I start
20 listing them, I forget one. So sometimes those offices are
21 headed up by somebody who we just literally had to pull from
22 somewhere else in the organization. Sometimes they are

1 bringing together lots of work that are actually going on
2 across the whole organization.

3 So the Office of Behavioral Health Equity, for example,
4 has just been added to Lark's responsibilities. And she has
5 many. But she's really working with a whole team of people
6 across all of the organization. So maybe she'll talk a
7 little bit about that as well.

8 The other thing we're going to do today, which I'm
9 really excited about because it involves you, and that is
10 that Stephanie brought to our attention last time something
11 about nicotine replacement therapy and working with our
12 populations. So some work has gone on about that because of
13 that. And she and Fran, they're going to talk a little bit
14 about that and how we're trying to resolve it. So we really
15 want our advisers to play a role for us in specific areas
16 that we're working on.

17 Kate Aurelias, who, unfortunately, as you know, is not
18 going to be with us on this council anymore, but she had
19 started working with Pete and some other folks on some of
20 the quality issues as well. So we're going to continue to
21 reach in and ask some of you to play a role with us on
22 particular things.

1 And, Don, I appreciate yesterday you agreeing to help
2 us on the professional training discussion, wherever that
3 takes us.

4 So, Wes, I don't know if you were in the room when that
5 happened, but you have another assignment, which is we have
6 six people who volunteered yesterday to have a conversation
7 by phone with you about what could we do or think about in
8 terms of professional training, professional -- as opposed
9 to peers and other kinds of folks who might work in the
10 system. But it was an interesting dialogue. So we'll get
11 you the names, Wes, and you can get people on the phone. I
12 think Stephanie agreed to work on that one as well.

13 But we have folks from, I think, all of the adviser
14 committees or several of them that agreed to help on that,
15 or at least have that conversation. So thanks for doing
16 that. So I'll have that more this morning.

17 And then we're going to spend also a little bit more
18 time this morning on our prevention strategy and just where
19 we are with some of that work with Fran. So that's the
20 morning.

21 And any questions about the agenda? All right.

22 Well, let me open up the floor for a moment and see

1 what your reactions were to yesterday, any of the topics
2 from yesterday that you would like to sort of just reflect
3 on some more. That particular environment that we had in
4 format yesterday is necessary in order for people to hear us
5 on the Web and on the phone. But it's not very conducive to
6 interactive discussion. So as a smaller group, let's see
7 what you think about what was going on in the room yesterday
8 and the topics we covered.

9 Yes, Larry?

10 MR. LARRY LEHMAN: Thank you. Really linking together
11 two of the thoughts from Kathryn's two presentations, one
12 with regard to post-event response and support to disaster,
13 including interpersonal violence, which is, frankly, the
14 most common type of disaster that we experience, including
15 in the workplace and including in health care situations.
16 And I was also glad that someone brought up the issue of
17 domestic violence as well.

18 In any case, you talked about the -- what you're
19 calling the mental health first aid. We have what in V.A.
20 we call psychological first aid. And we also have something
21 called skills for psychological recovery. And I think
22 that's the point that I wanted to bring up, the fact that

1 what we're -- one of the things we're trying to do is to
2 develop people's coping skills and capabilities in response
3 to overwhelming threat and disaster-type situations.

4 I think that fits actually very well with the concept
5 of recovery and resilience, particularly resilience. It's
6 one of the things that folks in the Department of Defense
7 and V.A. are working on, how we develop -- you totally avoid
8 the word "mental" in what you're doing, or even
9 "behavioral," but talking about skills development, problem-
10 solving skills that help you to address issues, including
11 stress-type situations and training people up to do that
12 actually before the event. And I think that's the aspect of
13 resilience that's a very important public health problem and
14 a very interesting public health approach that SAMHSA could
15 get involved with.

16 In other words, if we start training people up really
17 from the time that they're in school to develop better
18 coping and problem-solving skills to deal with things that
19 are unexpected to strengthen themselves and their ability to
20 solve problems and understand emotions that could be
21 identified from the sense of physical sensations of tremors,
22 anxiety, whatever. When I think can develop better skills

1 at preventing or minimizing the psycho-pathology and psycho-
2 social problems in association with stress. And it's
3 something to think about, that idea of trying to -- and it
4 may well tie into prevention. So the message is training
5 people in coping skills and management of stress before
6 event as well as after.

7 MS. PAMELA S. HYDE: Yeah, thanks, Larry. That's
8 really interesting because, you know, some of the work we've
9 been doing in the major disasters, the big -- you know,
10 whether it's Katrina or the oil spill or now the Arizona
11 shooting or other kinds of things have led us to think about
12 this issue of preventing behavioral health impacts of
13 disasters. And then you have certainly raised the issue of
14 individual coping skills for traumatic events.

15 But luckily, we have a person who's the Assistant
16 Secretary for Preparedness and Response in HHS who is a
17 practicing physician. She still sees patients every
18 Wednesday and is very clear she wants to continue doing that
19 and also has a background in behavioral health. She's not a
20 psychiatrist or that kind of a physician, but she has a
21 background in it. And she's very interested in this issue
22 of behavioral health in disasters and particularly in the

1 prevention aspect of it. And I think we are getting better.

2 And you guys should jump in, center directors and
3 others. I think we're getting better about knowing how to
4 respond to the behavioral health issues in a disaster. But
5 preventing them is probably not something we've taken on in
6 the biggest sense of the word. So your point is really
7 well-taken. And it may go to that issue of national
8 dialogue or where we're going to go with that and what we're
9 going to do with it.

10 Lark, this is a good time for you to come. Larry's
11 raised the issue of resilience and how we are prepared to
12 prevent traumatic -- the impacts of traumatic experiences,
13 whether it's either at the individual level or in a major
14 population, a disaster-level, et cetera. So that's what
15 we're talking about.

16 All right, other people have reaction to that? Or
17 anybody else want to comment?

18 MS. A. KATHRYN POWER: Well, Larry and I had a
19 conversation about this yesterday. And we began to link
20 some of the work that's going on, not only in sort of
21 disaster response and anticipating trauma and the
22 recovery/support issue, but also the work with military

1 families and how, if you will, looking at lifelong building
2 of skills and capabilities. It really is a continuum. It's
3 this inoculating children with emotional competency skills
4 in a way that is much more direct and much more reflective
5 of the current science about how we can do that. And that,
6 in fact, embeds stronger and deeper resiliency skills across
7 the general population.

8 And that, in fact, and in turn, I think, helps inform
9 and raises the public's ability to react to and heal from
10 ongoing traumatic events. So if we can become much more
11 organized about that, I think that has great influence
12 across the populations and across the strategic initiatives.
13 And some of the work that the V.A. and DOD are doing
14 relative to looking at resiliency skills we're starting to
15 have some conversations with them about that and how do we
16 think that that needs to be incorporated in ongoing
17 education and awareness building across the population. So
18 I think there's a lot of rich dialogue that can occur from
19 that.

20 MS. KANA ENOMOTO: Larry, I just wanted to make
21 somewhat of a distinction between what you're saying, mental
22 health for state and what you guys call psych. for state.

1 They are actually two different models. And psych. for
2 state really is about helping people respond in a crisis and
3 is more oriented, I think, towards professionals or people
4 with some -- with already some existing clinical training
5 and how to respond in the aftermath of a disaster or a
6 traumatic event.

7 Whereas mental health for state really is that broader-
8 based public education-type of effort to really orient
9 people to what are the signs and symptoms of all mental
10 illnesses and addictions and get them more comfortable
11 talking about it. And I think that is a precursor to
12 raising the comfort level of folks to have the conversations
13 before that occurs because they are understanding better
14 what these illnesses are and then they can talk about how do
15 you prevent them, how do you get ahead of them.

16 MR. LARRY LEHMAN: I'm going to make a point of
17 following-up with you then and finding out what the aspects
18 are of that approach that we can look at it and see how it
19 relates to the things that we're doing and sort of improve
20 and enrich what we're doing.

21 MS. PAMELA S. HYDE: Great. Thank you.

22 Other comments about yesterday?

1 Yeah, Don?

2 MR. DONALD ROSEN: I was just thinking more about
3 education and how to get the word out. And there's an
4 emerging field of student collegiate mental health that is
5 growing in leaps and bounds. There's actually a post-
6 psychiatric residency training fellowship, which the first
7 one just started specializing in collegiate mental health.
8 The institution where I'm about to transition to go to work
9 has an annual conference on collegiate mental health. And I
10 don't know if folks in this group know about that. But it
11 might be an interesting liaison activity.

12 MS. PAMELA S. HYDE: Actually, that would be very
13 interesting to know because we have been thinking about --
14 I'm very conscious of the fact that we touch campuses in a
15 lot of different ways in the agency in different centers and
16 different ways. And so, we've been sort of thinking about
17 that, especially in the wake of Tucson about especially
18 reaching out to college campuses, I mean, community college
19 campuses. But so we've sort of been thinking about our
20 campus work. So that might be a good connection.

21 MR. LARRY LEHMAN: I'll send you some information.

22 MS. PAMELA S. HYDE: Great. And where are you moving

1 to?

2 MR. DONALD ROSEN: I'm moving to the Austin Rigg Center
3 in Stockbridge, Massachusetts. I'm going to be their next
4 CEO and Medical Director.

5 MS. PAMELA S. HYDE: Oh, cool. Great. Well,
6 congratulations.

7 MR. DONALD ROSEN: Thank you.

8 MS. PAMELA S. HYDE: All right.

9 Anything else from yesterday?

10 Cynthia?

11 MS. CYNTHIA WAINSCOTT: Yeah, I was really struck by
12 the sort of divergent perspectives of the people in the room
13 and thought it was extremely healthy that we had them there
14 and that we heard them. But I did think that it pointed out
15 one thing. And that is the need to sort of explain better
16 on a community-to-community basis the underpinnings of some
17 of the things you're doing. I think people who were there
18 in the room heard it, but I think it was a kind of a canary
19 in the mine that other people may be misunderstanding
20 because of language or because of the lack of their thing
21 not being right on top, that there are some opportunities in
22 liaising, I think, with constituency groups. And I was a

1 little surprised by that, frankly.

2 MS. PAMELA S. HYDE: Can you say more about that and
3 just in terms of how it struck you? Because I can tell you
4 how it struck me, but I sit and live this every day, so I'd
5 be interested in how you heard it.

6 MS. CYNTHIA WAINSCOTT: For people who have not been in
7 on the discussions for what language ended up on the paper,
8 I'll just take an example. If you are a woman's advocate
9 and you did not perceive that women were strongly listed on
10 every page, that concerns you. If you were a prevention
11 advocate, you're probably pretty happy this year. But
12 everybody's got their own top of the list thing. And
13 anytime you do a strategic document, some people are going
14 to be happy about where they end up, and others are going to
15 be less happy about that.

16 There will be -- I think another one that struck me was
17 fear, I think is the right word, that peer services somehow
18 are no longer going to be as valued and as encouraged. And
19 you actually talked about how you had changed some of the
20 way the thing looked by the input you got. But I think
21 there's just a real opportunity to build bridges of
22 understanding between constituencies by simply asking them

1 what are you concerned about and then answering them. You
2 would learn something. The danger in that, I think, is
3 people may think that you can go back and reorder the
4 strategies you can -- you know, you're not going to do that.
5 That has to be a first understanding.

6 And I don't think it's surprising that people take that
7 stance because it's all about programmatic primacy, you
8 know. But I think it was -- I was surprised at the
9 intensity of some of it.

10 MS. PAMELA S. HYDE: Anybody else have a reaction to
11 that before I react to it? One of the things that we've
12 been doing -- and, Flo, you've participated in some of this,
13 and others have. You know, when I first got here, and Mark
14 and I had some conversations about language. And we put out
15 a thing in the first month or two. I think Wes was in on
16 that conversation, too, was just putting out to the field
17 what's in a term. You know? Let's talk about language.

18 And so, we started something that, in a funny way,
19 started kind of slow. And it's now building about a year
20 and three months later, is building with the how we use
21 language and what does it mean. And so, people, I think --
22 I don't know if that turned out to be a good thing or a bad

1 thing because, on one hand, it's allowing us to have the
2 conversations. And on another hand, it is sort of getting
3 us to pay attention to terms in ways that people are now
4 sort of worried about what a particular term means.

5 And, for example, Mark and I were talking about one day
6 in the executive leadership team. I said, "Okay, we're
7 going to take the word "care" out of health reform, health
8 care reform." And if you stop and think about that, you're
9 going to take "care" out of health reform? And yet,
10 yesterday we had a person from the audience say, "You
11 shouldn't use the word "care." It's like, okay. So maybe
12 that's validation of saying health reform rather than health
13 care reform.

14 And then obviously, we've been having lots of
15 conversation about the use of the term "behavioral health."
16 We explicitly made a decision not to do population-based
17 initiatives, even though we've been asked to. We've been
18 asked to do that about people who are minorities. We've
19 been asked to do that about Native Americans. We've been
20 asked to do that about children and other groups. And we
21 explicitly did not put specific populations by age, gender,
22 race, sex, anything else, other than military families.

1 Military families is the one population-based
2 initiative that we have. And, of course, that covers
3 everything from women, men, kids, LGBT, Black, African-
4 American, Asian-American, Native-American, et cetera. So
5 it's everybody, more some than others. And it touches
6 people more, and some than others. It touches a different
7 age group in some ways. And yet, with veterans, it touches
8 all age groups.

9 So anyway, the point here is I'm fascinated now seeing
10 what reactions people have to terms or to language or even
11 the use of the term "peer," which we think of as fairly
12 broad. And people see it as fairly narrow, or at least the
13 person who spoke yesterday thought of it as fairly narrow.
14 So it's an interesting phenomenon that's going on in the
15 context.

16 MS. CYNTHIA WAINSCOTT: And I think it's healthy that
17 we're all thinking about this because the way people -- what
18 we say precedes how people hear us. And we have our own
19 language that means something to us. Mark's nodding yes.
20 It may mean something entirely different to somebody else.

21 My own personal history with the word "stigma" is years
22 ago, I started advocating strongly that we stop using it

1 because people didn't understand it outside of -- we went to
2 stigma -- and prejudice and discrimination. And now we're
3 back to people questioning should we be -- that's a healthy
4 thing. And I think what's underneath this is worries and
5 affirmation that because you don't love the way we said it
6 doesn't mean we don't think that what we're doing is
7 important. And you really, I thought, answered that well
8 yesterday a number of times, you and the staff, by saying,
9 well, yes, but it may not be
10 on the front page, but here's what we're doing. And I think
11 those kind of dialogues will be reassuring. And I think if
12 you choose to do this, you will learn things that will
13 surprise you about their perspectives.

14 MS. PAMELA S. HYDE: Yeah, absolutely, it is
15 surprising. And stigma is a great example. And we've got
16 people who are just all over us to take that off the chart.
17 Don't ever use that word. And then yesterday, again, we got
18 some pressure to -- maybe we should be using that word. We
19 clearly have -- I think, mostly from consumers and people in
20 recovery, feel like the word "stigma" is stigmatizing in and
21 of itself. It's a little bit like if you call for something
22 so often that you want to happen, then you almost keep

1 calling attention to the fact that it's not happening. So
2 there's a point at which you have to figure out what your
3 language is doing. So it is a fascinating thing. And we're
4 learning a lot, I think, by the dialogue.

5 MS. CYNTHIA WAINSCOTT: Well, and I just want to say
6 once more how appreciative I was yesterday of the staff's
7 stance to be non-confrontational, to continue to listen to
8 validate what people were saying. When you've done that all
9 day long, by about 4 o'clock, it must get hard. But you
10 really did a good job. And as a result, we had a great
11 dialogue, I think.

12 MS. PAMELA S. HYDE: Any other comments about this?
13 Yeah, Stephanie?

14 MS. STEPHANIE LEMELLE: Just along the -- about the
15 term "stigma." You know, in the medical field now, the
16 trend is to use the terms "bias" and "stereotype" because
17 the bias implies, you know, more of a decision action. And,
18 you know, stereotype applies both to the consumers' idea of
19 themselves and as others see them. So those are the two
20 terms that are primarily used in medicine now.

21 MS. CYNTHIA WAINSCOTT: But I would encourage us to
22 continue to use discrimination because you can't outlaw

1 bias. You can't outlaw stereotype. You can outlaw
2 discrimination. That's the thing you can really act
3 against. So, you know, I think it's a good way to talk
4 about it. But when you talk about action, you've got to
5 think about the discrimination results.

6 MS. PAMELA S. HYDE: That's a good point. I mean, we
7 have been using the word "discrimination" and "prejudice"
8 more. But, I mean, the underlying issue really is lack of
9 knowledge, I think. And I think some of these beliefs and
10 fears and other things come from lack of knowledge about the
11 realities.

12 Wes and I were just talking earlier today about another
13 group who has a disease that's struggling with the lack of
14 knowledge about that disease and stuff. And they really
15 want to separate themselves. "We do not want to be called a
16 mental illness." And it's like, well, why not? I mean,
17 what's wrong with being called a mental illness if being
18 called a mental illness gets you treatment and you know what
19 to do about it? Why do you not want to be called that? You
20 know, it's like because that's the prejudice. We don't want
21 to be called that thing.

22 So it is an interesting dialogue about that. But thank

1 you. Bias and -- what was the other one? Stereotype.

2 That's good. Thanks.

3 Remember that, Mark.

4 MR. MARK WEBER: I already wrote it down.

5 MS. PAMELA S. HYDE: Great.

6 Flo, thanks.

7 MS. FLO STEIN: I'm not sure if it was the most recent
8 SAMHSA brochure or newsletter, but there was one that had
9 your discussion of terms across the bottom. I just picked
10 it up the other day, and it came in perfect in a meeting. I
11 think there's a language discussion is critical. Whenever
12 you start doing integration, clarifying your words, your
13 language, your meaning, what your values are are important.
14 That's the only way you can actually do integration. So I
15 think SAMHSA's leadership around this is really important
16 because we've always had a problem with language, even
17 amongst ourselves. And now we're trying to move into a
18 larger arena.

19 MS. PAMELA S. HYDE: Yeah. That's a really good point
20 because as we get into the health care world, you know,
21 they're going to use words like "disease" and "illness."
22 And that's not going to feel comfortable to some people,

1 patient, things like that. You know? I have to scratch my
2 head and just realize I've been in the middle of this term
3 discussion for almost 40 years, going back to when people
4 didn't like the term "patient" and "client." And so, we
5 came up with "consumer." And at the time, it was a new and
6 cutting-edge term. And now people don't like that so much.

7 Mark?

8 MR. MARK WEBER: One of the things that we're doing as
9 part of the Behavioral Health Coordinating Council across
10 the department is developing a glossary of terms. And being
11 very candid about it, you know, sort of threw it out there
12 as red meat. And so, the reaction is happening internal.
13 We're working with the institutes, in particular, about
14 terminology. And the immediate feedback I got is, well,
15 SAMHSA's not going to tell us what words to use. You know?
16 And it was like, well, no, what we're trying to do is come
17 up with a term and a definition so that we can be
18 consistent, not only within SAMHSA and with the institutes,
19 but ultimately across the Department of Health and Human
20 Services.

21 So that's something you all will be seeing. It will be
22 one of those living documents that never is final, I

1 imagine. But it has created quite a good discussion inside
2 of the department as well. So hopefully, that will be a
3 helpful tool.

4 MS. PAMELA S. HYDE: Kathryn?

5 MS. A. KATHRYN POWER: One of the reasons, I think,
6 that we have these cyclical discussions about terms and
7 particularly about the term "stigma" is because we have
8 other sectors coming into the discussion relative to Flo's
9 point about it's not just us folks anymore. I'm telling you
10 the Department of Defense is never going to use the term
11 "bias, stereotyping, discrimination or prejudice" because
12 they will never say that that's what they're doing.

13 And so, we have to figure out how to accommodate that
14 mindset in terms of the use of those terms and educate them,
15 to the extent we can, with why, in fact, it's not a useful
16 term, if that's our current thinking. But they'll never use
17 those other terms that we find acceptable, you know, on a
18 civil society basis or on a personal basis because they
19 won't see themselves having that kind of behavior as a part
20 of their institution. So that changes the dynamic when you
21 have other players now talking about these terms.

22 MS. PAMELA S. HYDE: Yeah, that's a good point because

1 some folks are now using "emotional health" or
2 "psychological health" as a more appropriate term. And that
3 talks to some parts of our systems and not to other parts of
4 our systems or people or constituents. So it is hard to
5 know.

6 I also was -- there's another term that -- I just lot
7 it. It'll come back to me, but the term that -- oh,
8 "civility." A city that shall remain nameless that I was in
9 one day, because I've been in lots of cities over the years
10 doing consulting and such, but I was in a conversation years
11 ago, probably 20 years ago. And the police chief there was
12 saying we need to start a dialogue about a more civil
13 society. And people pooh-poohed him and that term. And at
14 the time, I have to admit thinking, yeah, that's a pretty
15 good idea. But, you know, the group at the time was clearly
16 not ready to go with civility as the thing we should talk
17 about.

18 And now, the mayors and the president and everybody
19 else is calling on all of us to have a more civil discourse
20 and civil society. So it is interesting how it's cyclical
21 in that regard.

22 The one thing I care about terms, Cynthia -- and I

1 appreciate you bringing it up because we have definitely
2 been spending time thinking about this and talking to each
3 other about it and talking to stakeholders about it and such
4 -- is it would be really easy for us to spend a lot of time
5 sort of inside our box talking to each other about sorting
6 stuff out and losing track of the world out there that we've
7 got to relate to. And so, we've got to keep that balance
8 somehow as we have this dialogue.

9 MS. CYNTHIA WAINSCOTT: As I read the strategic
10 document, I was struck by how really well, I thought, the
11 vast majority of it didn't do one of the things that I worry
12 about, which is talk about physical health and mental
13 health, which indicates that it's two things, when, in fact,
14 we're arguing that it's -- the brain is part of the body.
15 But if you will look on the first few pages where we are
16 quoting other people, which was one of the points that you
17 made yesterday, we do say physical health and mental health.
18 Unfortunately, that's a lot of what people are going to look
19 at, remember.

20 But if you dig into the document, we talk about mental
21 health and general health, medical health, other health
22 repeatedly. So clearly, we're getting it, that particular

1 thing, which is important to me because I think we're
2 teaching people the right thing if we don't say "mental and
3 physical." But when we quote people, we end up using what I
4 think is kind of the old language. So it's a process, for
5 sure.

6 MS. PAMELA S. HYDE: Well, it goes without saying -- we
7 usually bring him down and clap for him because he did such
8 great work on this -- David, who helped do most of the
9 writing on the final document. There were several authors
10 as the process went through. But in terms of getting the
11 final document, he, with some guidance from Kana and help
12 from all the strategic initiatives, tried really hard -- I
13 mean, every word in that thing is very carefully thought
14 about. It doesn't mean that we didn't make some mistakes.
15 But it wasn't done lightly, I can tell you that.

16 FEMALE SPEAKER: For show.

17 MS. PAMELA S. HYDE: Yeah.

18 Fran?

19 MS. FRANCES HARDING: I just wanted to say that the
20 whole conversation of language and terms is extremely
21 important for the entire continuum, especially the
22 prevention continuum, part of the prevention -- the

1 continuum where prevention is. And just the difference
2 between promotion and prevention has been causing pain
3 across our new field of behavioral health. And we're very
4 used to that.

5 We used to start with bio-cycle social versus agent,
6 host and environment when we were talking about the
7 difference between substance abuse and alcohol or drugs and
8 alcohol. Then we're moving into now primary, secondary,
9 tertiary, which some people have never left, into universal,
10 selected and indicated. Well, then we keep talking about
11 it, and now the IOM shows us that we need to use both of
12 these terminology together. We need to use primary,
13 secondary and tertiary if we're getting closer to physical
14 health. We're back to that. And at the same time, we don't
15 want to lose universal, selected and indicated.

16 So I think this whole -- it takes from the lowest of
17 communities, who are really starting, right to the very top
18 of our doctors and medical professionals, both in the
19 addiction and physical health world. So it's a very good
20 discussion, but it shouldn't be a surprise to anyone how
21 this is taking a long time and that we're struggling with
22 this.

1 MS. PAMELA S. HYDE: So, yeah, Pete?

2 MR. PETER DELANY: The part that, I think, a lot of
3 people forget about is that language has impacts on other
4 stuff like data. And every time I go to Data Council, you
5 know -- because we try to be very precise in what we
6 measure. And that always causes problems because nobody
7 likes some of the terms we use. But, I mean, we were in
8 Data Council recently, and we were talking about the issue
9 of disparities. And at some point, we've got so many groups
10 that are pushing for us to measure, that we actually don't
11 have enough people to be able to sample, unless we sampled
12 at the U.S. level.

13 So I think that's something that we have to think about
14 that we struggle with, too, is it's not just, you know, the
15 language that we use and how it affects the power of what
16 we're doing in terms of programming and policy, but it
17 trickles down into the data. And it can -- it does cause a
18 significant amount of effort to try to make sure that we're
19 able to support and provide information on the things that
20 are happening.

21 So, you know, as we move forward with, like, even
22 workforce, the language you use in workforce, if I'm trying

1 to work with staff and trying to figure out how to measure
2 that, that can impact whether we're actually going to get
3 anything worth talking about. So I think this has been my
4 plea all along, is that data -- thinking about the data and
5 thinking about information has to be part of any of these
6 discussions. And it's good to be precise and inclusive.
7 But it's also good to include what you're trying to be able
8 to say with that.

9 MS. PAMELA S. HYDE: Yeah, thanks.

10 One more comment about this, and then we'll move to
11 some other topics. But one of the things that is hard about
12 language -- and, Cynthia, your point is well-taken -- is we
13 have to have the conversation about why are people reacting
14 to it that way because it's that underlying issue that's
15 more important -- is we've really just tried to say, look,
16 what we need to do is have enough trust among the behavioral
17 health community -- and people won't like that term, either
18 -- to at least say I'm not going to make assumptions about
19 what you believe or what you're trying to accomplish by the
20 language you use until I have the conversation with you
21 about that.

22 So that's the thing, is just building some trust and

1 understanding that however people are using terms, and
2 particularly how SAMHSA is using terms, shouldn't be an
3 assumption about values or commitment or services or
4 anything else until we have that conversation. And there
5 very well may some places where we actually do mean to be
6 making a distinction between this or that, and people need
7 to know that. And we do need to have some consistency in
8 the way we use the term in order to measure it, in order to
9 make sure that we're saying what we're committed to and what
10 we aren't and in the time we're in, where we are committed
11 to lots of things but have absolutely no resources to do
12 them.

13 So we're having to make some tough decisions about what
14 we act on today versus what we're going to have to wait on
15 until we see what Congress does or what the next few years
16 bring or whatever. So all of those things are important.
17 It is important that we have some words we land on and keep
18 using so we aren't continuing to confuse people about what
19 we're trying to say. So we are struggling with that.

20 And the other thing that came through, I think,
21 yesterday and even in this conversation is that clearly, the
22 public awareness and support initiative and the data quality

1 and outcomes initiative is cutting across all the other
2 ones. I mean, in some ways, all the initiatives cut across
3 all the other ones. But those in particular, I think we
4 know we need communication plans around each of the
5 initiatives. And we have data issues around each of the
6 initiatives. So as we proceed, those have sort of both
7 free-standing responsibilities as well as responsibilities
8 with the other ones.

9 Okay. Again, I want to just -- we do have a quorum
10 now, so we're going to go back to the business in a minute.
11 But let's continue for a few more minutes on yesterday.

12 The other things that came out were this notion -- and,
13 Larry, you were kind of, sort of, raising it, this every-day
14 disaster of untreated mental illness and substance abuse.
15 An interesting idea came out of that discussion about if we
16 have a universal, across-the-country 911 program where
17 everybody knows they can call 911 in a situation in which
18 anything is problematic, people actually call for medical
19 issues, for legal issues, for, you know, safety issues, all
20 kinds of things they call 911. Why couldn't we have a 711
21 or a 211? Well, there's already a 211 for something else --
22 or a, you know, some number that's, you know, behavioral

1 health crises or needs?

2 It was an interesting idea. But it raises for me the
3 issue of, well, do we want to be separate from 911 or do we
4 just want the 911 process to connect people up to the right
5 kinds of crisis or issues. So that came up yesterday.

6 The college campus issue came up several times
7 yesterday. The role of youth came up several times
8 yesterday. This issue of private or professional provider
9 training and standards came up yesterday. Women's issues
10 came up yesterday. And then just there were some questions
11 yesterday about things, as I said earlier, that we -- I
12 think people asked about because we didn't do the whole
13 eight initiatives again. We picked off pieces.

14 We're sort of drilling down now. And, like, the
15 quality conversation, for example, I think, was a reflection
16 of we're drilling down below the initiative level and into
17 some of the work level. And it's a much more beginning set
18 of a dialogue rather than a fully baked set of dialogues.
19 And I thought that was a really rich discussion about the
20 emotions and the interest people have in that issue. So
21 anyway, those are other things that I heard yesterday.

22 Are there other things you heard yesterday that you

1 want to reflect on? Obviously, a whole lot of tribal issues
2 yesterday as well that we will take up some with the stack
3 this afternoon.

4 Other things?

5 MR. TERRY CROSS: Pam, I just want to comment on the
6 richness of the discussion on the tribal issues, and in
7 particularly, linking that back to the day-to-day tragedy of
8 these issues. And we had an opportunity to sit down
9 together for lunch with Sheila and listed around the table a
10 tragedy in almost every community. And that really comes
11 home to particularly link them back to your initiative on
12 trauma.

13 It is such an important part of this work. And I think
14 -- or I really want to -- I see that as a package. And I
15 just really want to emphasize and thank SAMHSA for the
16 inclusion of the tribal discussion yesterday and these
17 issues in this -- in your set of initiatives. And I think
18 the report highlights that so well and ties that together.
19 And that came out in the discussion yesterday.

20 I also was -- I'm frequently the only Indian person in
21 a crowd like this. And I have historically been in meetings
22 where the Native people were the last to contribute or to

1 speak up. Things have changed. So thank you very much.

2 MS. PAMELA S. HYDE: Yeah, Terry, it was nice. We've
3 got a lot of very knowledgeable and willing to participate
4 folks on all the committees. So it's really good.
5 Appreciate that.

6 And, by the way, Terry and Hortensia, welcome. You two
7 want to just take a minute to introduce yourself? Because
8 we did that before you got here. And then --

9 MR. TERRY CROSS: Well, and my apologies for being
10 late. If you have read the book, "Outliers," you know, that
11 there's seldom one factor that contributes to a disaster.
12 So I'm Terry Cross. I direct the National Indian Child
13 Welfare Association. I'm a member of the Seneca Nation of
14 Indians.

15 MS. HORTENSIA AMARO: Good morning. I'm Hortensia
16 Amaro. I'm sorry I couldn't be here yesterday. I had to
17 teach, so I had to fulfill my responsibilities as a
18 professor. I am Associate Dean of Urban Health and
19 Distinguished Professor of Health Sciences at Northeastern
20 University, where I also am the Director of the Institute on
21 Urban Health Research. And my work has been on -- being
22 community based, substance abuse, interventions, including

1 integrated trauma treatment, mostly for women, but in the
2 last five years, we've started doing a lot of work with men
3 and have developed programs with men. Most of my work is in
4 collaboration with the city health department and with the
5 state health department.

6 MS. PAMELA S. HYDE: Thanks, Hortensia.

7 I think I saw a hand over here. Yeah?

8 MR. ARTURO GONZALES: Reflecting on language and things
9 that transpired yesterday, I was -- in looking at the area
10 of public comments, I was a little bit concerned about a
11 comment that was made. And I guess the comment made was
12 about data bases and getting information and that in a rural
13 Indian country, that most surveys lack validity. There's no
14 reliable data on the prevalence of behavioral health issues
15 in rural and Indian country, was the comment that was made.

16 Is that true, Pete? I don't think -- I was sitting
17 back, and I was saying, "What do you mean there's no data on
18 rural initiatives or behavioral health initiatives"? And
19 there may be a lack of that. There may be a lack of data on
20 -- for example, when I look at rural New Mexico, I think
21 we've tried to get a lot of data. But maybe I'm wrong.
22 Maybe does SAMHSA have enough -- there's certainly a lot of

1 data with regard to urban issues, a lot of research being
2 done there. But if there isn't, then how do we address
3 that?

4 I mean, we're talking about, you know, an ad hoc group
5 that was set up yesterday for manpower issues and training.
6 Do we need to have an ad hoc group that looks at the lack of
7 data with respect to Indian country and rural areas? I
8 think of Latinos now with the change in the census and
9 becoming the largest group in this country. What does that
10 mean from the standpoint of projections and dealing with
11 issues and potential epidemics or catastrophes? Do we need
12 to be proactive in looking at where those gaps are and how
13 do we get that? That all of a sudden is a real big concern
14 for me.

15 MS. PAMELA S. HYDE: Pete, before you answer that, I
16 don't think you were in the room. I didn't see you when
17 this comment was being made. But the person said -- it was
18 obviously talking about telephone surveys and saying that
19 national data bases using telephone surveys, but in rural
20 Indian country, those surveys lack validity and no reliable
21 data is available on the prevalence of behavioral health
22 issues in rural and Indian country. And I know, having done

1 a lot of telephone surveys in New Mexico, where there's a
2 lot of Native Americans without phones, we dealt with this
3 issue as best we could. And I think it's probably safe to
4 say that they are not as reliable as probably some of the
5 other data. But to say they're not reliable at all, I
6 thought, was a little bit of an overstatement.

7 MR. ARTURO GONZALES: Or that there is no data was more
8 concern.

9 MS. PAMELA S. HYDE: Yeah.

10 MR. ARTURO GONZALES: I think there's some response
11 that we need to take a look at there.

12 MS. PAMELA S. HYDE: So, Pete?

13 MR. PETER DELANY: Well, yeah, I think there are
14 challenges to using, especially telephone surveys, whether
15 you're in rural areas or not, because the response rate is
16 relatively low. And they're only coming online with new
17 technologies to deal with cell phones now. Part of the
18 problem is even in urban areas, people are moving off land
19 lines and onto cell phone only. So there's a lot of
20 challenges. And it really creates a -- there are new
21 methodologies being developed to figure out how do you use
22 the data without over-selling it or under-selling it.

1 As to some of -- there are data sets. I mean, we do
2 have -- we do over-sampling, at least in our national
3 household survey. We do over-sampling in rural areas. We
4 are not as well-established in tribal communities as we
5 would like. We are in there, but we are not as well-
6 established. I'm not sure that we need to develop a task
7 force. It's something I'm working with IHS to figure out
8 how to do it. And, you know, there are a lot of challenges
9 to going into tribal communities because there's an
10 ownership of data issue. And when I collect for the federal
11 government, this comes back under a statistical unit issue.

12 We make all the data available to anybody. But it's
13 held in trust for all of the public, not just for the tribe.
14 So, I mean, there's a lot of negotiations. And I've been
15 working with a number of people to try to improve that.
16 And, you know, so I'm not sure I need a task force. But,
17 you know, maybe -- Pam and I actually have on our agenda for
18 Friday. It's on Friday -- to talk about getting some
19 increased assistance to try to kind of move into that area
20 now and to try to see how we can build a greater
21 relationship so that we can get into areas we haven't been
22 able to get into before.

1 MR. ARTURO GONZALES: Well, I'm even thinking, Pete,
2 what about the rural Hispanic areas, irrespective of Indian
3 country. I mean, there's such an overlap. Like, in our
4 state, there's such an overlap between Indian country and
5 Hispanic rurality, it's hard -- what affects one may affect
6 the other. And yet, there may be some differences. And I
7 just want to make sure that when we look at issues that we
8 have, particularly as health care reform comes into place
9 and you're talking about bringing people in from rural areas
10 to participate in insurance coverages, that we have the
11 information or we know where to, at least, begin to ask the
12 questions on those groups that may not be represented in
13 common data collecting techniques.

14 MR. PETER DELANY: Well, I think maybe the best thing
15 is let me develop a report for you on what we do do.

16 MR. ARTURO GONZALES: Okay.

17 MR. PETER DELANY: So you have an understanding of
18 where we are.

19 MR. ARTURO GONZALES: Okay.

20 MR. PETER DELANY: And then maybe get some assistance
21 in thinking through where the gaps may be.

22 MR. ARTURO GONZALES: That'll be fine, yeah.

1 MR. PETER DELANY: Yeah, I can develop that pretty
2 quickly.

3 MR. ARTURO GONZALES: Yeah.

4 MS. PAMELA S. HYDE: You also should know, actually,
5 that there is an HHS task force on data in Indian country.
6 And it is working with the secretary's stack, which we are
7 on. So this issue is at a higher level, and there are
8 native leaders and native folk who are on that committee
9 working with the HHS as a whole, whether it's NIH
10 information or whether it's CDC information or our
11 information or whatever. So it's a bigger than SAMHSA
12 issue. That doesn't mean we don't have our own issues. But
13 it's bigger than SAMHSA.

14 I saw Lark's hand and then Terry's hand.

15 MS. LARK HUANG: Yeah, I was going to add to that. It
16 is bigger than SAMHSA. And in the secretary's Disparities
17 Council and this new strategic action plan that I'll mention
18 later, data is a big issue because our standard sampling
19 frames across the nation aren't necessarily going to pick up
20 disbursed rural populations in a representative way. So
21 Pete, for example, collapses over years. But we can't
22 always over-sample because of the finances involved in that.

1 So we're looking actually at different methodologies for
2 getting those populations that are very disbursed or very
3 not densely populated, but kind of disbursed in larger rural
4 areas.

5 But I think we're also moving more towards county-level
6 data, looking at what pictures of counties exist. And
7 there's some really, I think, very exciting efforts that are
8 putting out now county data, collecting it from multiple
9 federal surveys to paint pictures of counties that's not
10 just the health conditions, but some of the things that
11 would be considered the social determinants in those
12 counties, collecting it across counties so you can see what
13 are the risks or what are the assets in communities, too.

14 And I think that begins to look at more county-level
15 data amassed from different -- not even just HHS surveys,
16 but labor surveys, Census Bureau surveys that really paint a
17 really interesting picture and how counties know what they
18 need to start targeting. And I think tribes are very much
19 part of that conversation as well, how do you really do that
20 within tribal communities as well as Latinos.

21 And we actually did -- here we did a population mapping
22 of projected minority population growth for the next 10

1 years. We just did it so we could see what are the
2 projected trends and where our investments are, you know,
3 and where the Latino populations are really growing and
4 where our particular grant programs are. So I think all of
5 that will help us sort of do better decision making around
6 policy and programming, too.

7 MR. ARTURO GONZALES: Can you share that stuff with us,
8 that information or some of the projections?

9 MS. LARK HUANG: Sure. I've presented it before. I
10 didn't get a chance to put it on my slides here, but, yeah.

11 MR. ARTURO GONZALES: Okay.

12 MS. LARK HUANG: I mean, it's Census data.

13 MR. ARTURO GONZALES: Okay. If not today, you know, at
14 some point.

15 MS. LARK HUANG: Sure. Sure.

16 MS. PAMELA S. HYDE: Good.

17 Terry?

18 MR. TERRY CROSS: Well, some of the data problems has
19 to do with the fractured nature of where the data comes
20 from. And so, for tribal communities, some is federal, some
21 is state, some is county, some is tribal. And you can't
22 sort it very well. You can't tell whether -- you know, how

1 the data matches up. And we have the same problem in child
2 welfare. Some of that is also complicated by access to
3 services. And the folks who -- if the numbers are coming
4 out of utilization data, if you don't have access to the
5 services, then you don't get counted.

6 And in national data sets like the YBRSS Youth Behavior
7 Risk Assessment Scale, we tried to use that for getting some
8 comparison data on a study. And we had to aggregate over
9 three years the data set in order to get enough Indian
10 people in this survey to compare. And then you lose
11 variables. This is a real issue in Indian country.

12 I serve on NCAI's Policy Research Center board. And
13 we're grappling with these issues. And tribes themselves
14 want this information, want this data. So this is a timely
15 discussion and an important one. But I think that while
16 some of the issues are unique to tribes, I think the
17 question about rural data is not dissimilar because it has
18 more to do with access to service and representation and
19 sample sizes. And so, in Oregon we've been able to do some
20 coalitions between rural providers and tribal providers in
21 order to attack some of those issues.

22 MS. PAMELA S. HYDE: Yeah, thanks. This is, I'm sure,

1 a larger discussion. And we'll have more of it probably
2 when we do the behavioral health equity stuff. So let me
3 try to get us onto that. I want to ask you one other
4 question, and then we need to do some business work, and
5 then we'll get to Lark's presentation.

6 One of the things that came up yesterday and it's come
7 up a lot when we talk about the strategic initiatives and
8 the work that we're doing is being framed, I think -- I
9 think Victor framed it pretty well. And it's true, that we
10 really are trying to think about SAMHSA's role a little
11 differently. But in thinking about that, partnerships are
12 key. We can't do what either our current role or an
13 emerging role would do without some key partnerships.

14 And yesterday everything came up from education issues.
15 We do a lot with the Department of Education to child
16 welfare issues. We do a lot with ACF to juvenile justice
17 and adult justice issues. We do a lot with the Department
18 of Justice, workforce issues. We do a lot with HRSA,
19 obviously, Medicaid and health reform issues. We do a lot
20 with CMS and then some about stuff that we do at CDC. So
21 one of the things I was thinking yesterday was maybe what
22 might be valuable -- and I wanted your feedback -- at the

1 next time that we get all the councils together is to have a
2 panel from some portion of those other entities.

3 There's a lot of them. And we always struggle with
4 overwhelming you with information versus having time to
5 dialogue. So think about that in your response. But we
6 could get a panel, for example, of HRSA, CMS and ACF, for
7 example. Or we could get a panel of ACF, Education and
8 juvenile justice, for example. Or we could get IHS and CMS
9 and HRSA on workforce issues or something. But we could put
10 some panels together here. And our colleagues in the other
11 agencies have been -- optives, we call them here -- have
12 been extremely responsive in sending somebody to our events
13 to talk a little bit about what they're doing with regard to
14 behavioral health and how we collaborate. So I just am
15 curious about whether or not you think that would be a
16 useful piece on the agenda next time we meet.

17 MS. STEPHANIE LEMELLE: I think it's incredibly useful
18 to bring other agency reps to our meetings because, I mean,
19 as you know, there's so little cross-talk in other venues
20 that the more we can communicate with some of these other
21 federal agencies and let them know what we're thinking
22 about. And also in the interest of not duplicating work, if

1 they're working on a particular topic, then maybe we should
2 let them. And if there are things that they're working on
3 that we should be doing, it's helpful to have that. So I
4 think the more we can involve some of these other agencies,
5 the better.

6 MS. PAMELA S. HYDE: Do you think it would be -- and as
7 other people respond, would it be good to have other people
8 of other agencies from, like, mine or deputy or division
9 director levels? Or would you rather talk advisory
10 committee to advisory committee? And I don't know what the
11 advisory structures are in those other entities, so I say
12 that without knowing that. But nevertheless, what is that
13 reaction?

14 MS. STEPHANIE LEMELLE: You know, my gut feeling -- I'd
15 have to give it a little more thought. But my gut feeling
16 is that we probably don't want to talk to advisory
17 committees, because I think advisory committees are made up
18 of folks like us who have very different agendas. And I
19 think that talking to administrators, or to whoever their
20 liaison is to their administrator, would probably be more
21 productive. And they'd have a broader, sort of more
22 objective view, I think, about what the agency is doing and

1 more knowledge about the agency.

2 MS. PAMELA S. HYDE: Don?

3 MR. DONALD ROSEN: You know, just looking at workforce
4 development as an example of that, there's a piece of this
5 that has to do with volume of workforce providers. There's
6 a piece that has to do with the content of what we're
7 looking at in terms of workforce development and the
8 opportunities to address alignment issues that separate out
9 our mission here from academic medical centers' economic
10 realities. And it seems to me that the opportunity to have
11 content specialists as well as workforce volume specialists
12 and us in the same room would be ideal. And I agree with
13 Stephanie that the idea of advisory council to advisory
14 council -- I don't think that would be as fruitful.

15 MS. PAMELA S. HYDE: Okay, thanks.

16 Another comment about this?

17 Arturo?

18 MR. ARTURO GONZALES: I think it would be extremely
19 helpful to have that kind of a joint panel around -- from my
20 perspective, I think the doers like yourself, the decision
21 makers that -- or like your team that would be on the panel,
22 specifically, I'd like to hear what, for example, how HRSA

1 is envisioning this work of integrating medical primary care
2 and behavioral health. How are they -- I mean, if they're
3 going to be controlling some of the manpower issues with
4 respect to that, or at least the dollars there, how do they
5 envision using that? And how is what our concern is going
6 to be represented within the use of those dollars?

7 I think it would also be helpful to have a panel with
8 respect to -- as I was getting into it yesterday with Dr.
9 Clark, on health information technology from the standpoint
10 of USDA or FCC, how they see that development of those
11 information technologies being played out, you know, in
12 terms of broadband, in terms of rural communities or in
13 terms of doing the kind of work that's going to need to
14 support integration of behavioral health and primary care
15 from an information technology standpoint. I think those
16 things are very, very timely and very useful.

17 MS. PAMELA S. HYDE: Yeah, thanks. It is very timely,
18 for reasons I can't tell you. But you'll know soon.

19 MS. CYNTHIA WAINSCOTT: I fully agree that it would be
20 a profitable thing for us to have those discussions. And I
21 also agree that the people who have the most knowledge about
22 the agency would be the most useful to have here. And

1 that's staff.

2 MS. PAMELA S. HYDE: Okay, great.

3 One more comment about that?

4 MS. HORTENSIA AMARO: Thanks. I think that it would be
5 very useful, too, if you're doing work with the Department
6 of Defense, to have them present to us -- and I think you
7 mentioned criminal justice. But both of those have, I
8 think, specific issues that need to be addressed in terms of
9 gender and also communities of color because of the over-
10 representation of those populations in the criminal justice
11 and in the military.

12 And you probably know about the IOM Committee that was
13 just formed to look at substance abuse. I don't know if
14 the other members know -- assessment, diagnosis and
15 treatment in the military, not only for military personnel,
16 but for their children and families. And so, the report
17 that will be coming out will be important. I'm serving on
18 that committee, so I think that it would be important to add
19 those two other organizations.

20 MS. PAMELA S. HYDE: Great. Well, obviously, you
21 should connect up with Kathryn sitting there next to you, as
22 our military families lead on anything about that. But,

1 yeah, we could do -- I think, the opportunities are sort of
2 endless in terms of what we could pull together. And the
3 question is I think we need to step back and think about
4 what your interests are. But we also need to step back and
5 think about what do we need advice about that your knowledge
6 about some of these other relationships would be helpful to
7 you in advising us. So let us think about that a little
8 bit. And we'll try to think about some panels or a panel
9 that we might put together to bring some of our other
10 partners to the table.

11 So we could do a military one, or we could do a kids
12 one, or we could do a kids and youth one, or we could do a
13 workforce one. And, you know, it touches many different
14 things. So workforce and primary care, behavioral health
15 integration really is tied for us. And that, you're
16 absolutely right, is tied to the electronic health records
17 and health I.T. in a broader sense. So there's lots of
18 things we could pull to the table.

19 Okay, one more comment about this, and then we'll move
20 on.

21 MR. TERRY CROSS: I would relate this back to your
22 theory of change you had up yesterday and the bringing

1 things to scale and kind of putting into context that
2 SAMHSA's not a huge organization. And so, in part, the task
3 of SAMHSA is to give things away. And I was really struck
4 by our meeting with CDC last time and how it's caused me to
5 think about how to advise SAMHSA on giving things away to
6 CDC and are there other places and particularly, in the
7 context of the children's mental health issues and the
8 systems of care and how to think about bringing those things
9 to scale.

10 Because I think there is some dilemmas about SAMHSA
11 kind of owns a very rich resource of both quality data and a
12 systematic approach to children's mental health that works.
13 And yet, it has a dilemma of how do you bring that to scale.
14 And I think the only way to bring that to scale is through
15 giving it away. And that's a really hard thing to do. So
16 as we approach this issue and others, I think those
17 conversations, in particular, with the HRSA, it may be one
18 of the key elements to that. And this is a critical time to
19 do that. So this strategy about how do you take it outside
20 the boundaries of SAMHSA.

21 MS. PAMELA S. HYDE: You are absolutely right. And I
22 appreciate that frame, Terry, because for two or three

1 reasons. One is actually we had a comment yesterday about
2 recovery, the way you maintain your deal with or keep your
3 own recovery is by giving it away. I thought that was a
4 very excellent comment. And I've always been of the opinion
5 that, you know, some people try to make sure their agency is
6 strong by holding onto everything. I really think that we
7 make our agency stronger if we push it all out there.

8 And I can remember years ago, I had a children's
9 director who worked for me who kept saying, "But we need to
10 have the children's unit do this," and, "We need to have the
11 children's unit do that," and, "We need to have," and
12 finally, I stopped him and said, "No, I think what you need
13 to be is at all the other tables so that children is
14 everywhere instead of thinking that it's all just within
15 your unit because your unit can't do it alone."

16 And that conversation with him was really profound. It
17 literally sort of changed the way he thought of the
18 trajectory of his career, almost, in sort of giving away
19 children's issues and getting children's issues embedded in
20 other systems, in other parts of organizations and stuff.
21 And he's been a terrific advocate about that. So it's the
22 same principle. We're really trying to think about how do

1 we -- it's best -- I haven't used those terms, but it's a
2 great term. How do we give away behavioral health so that
3 everybody else helps own it and take it and move with it?
4 So that's good.

5 All right, Lark, you want to make a final comment here?
6 And then we're going to do a couple business, and then we're
7 going to come to Lark for the presentation.

8 MS. LARK HUANG: Yeah, I think we do a lot of giving
9 away with guidance. And I think we're looking at other
10 systems, and we've been sort of building that. And now
11 they're coming to us, both literally and figuratively.

12 We have USDA, which was mentioned somewhere, which has
13 a cooperative extension office in every single county of
14 rural hub piece. And they've been coming to us because they
15 are the largest funder of after-school programs. And they
16 want our prevention work.

17 In fact, they're coming to meet with a bunch of Fran's
18 people to talk about how can they take our stuff, you know,
19 and use it in their delivery system, doing a lot of the same
20 thing with some of the child welfare work in terms that they
21 want our trauma work and how do we put it into their system.
22 So I think it makes good sense for where we're at fiscally

1 as well has having the expertise and being leaders in that,
2 not shoving ourselves into other systems, but letting them
3 know we have something to help them get to their outcomes.

4 MS. PAMELA S. HYDE: Yeah, absolutely. Good frames.
5 Thanks.

6 Okay. We've got a couple of business things we need to
7 take care of. And we have a quorum now. So let's go back
8 and do that. And let me get to where I need to be to read
9 this on the record. Is this it? Okay.

10 Do we need to formally call it to order now again?

11 [No response.]

12 MS. PAMELA S. HYDE: Okay. We are formally already
13 called to order. I want to say that the minutes were
14 forwarded to all of you electronically for your review and
15 comments. They were certified in accordance with the
16 Federal Advisory Committee Act regulations. You also
17 received a copy of the certified minutes. If you have any
18 changes or additions, that will be incorporated in this
19 meeting's minutes. Are there any discussions on the
20 minutes?

21 [No response.]

22 MS. PAMELA S. HYDE: Okay, seeing none, I'll entertain

1 a motion to adopt the minutes.

2 MR. DONALD ROSEN: So moved.

3 MS. PAMELA S. HYDE: Let's see. Don moved.

4 MS. HORTENSIA AMARO: Second.

5 MS. PAMELA S. HYDE: Hortensia seconded.

6 All in favor, say "aye."

7 [A chorus of ayes.]

8 MS. PAMELA S. HYDE: Opposed?

9 [No response.]

10 MS. PAMELA S. HYDE: Thank you. The minutes are
11 adopted.

12 All right, is there another formal thing we have to do?

13 [No response.]

14 MS. PAMELA S. HYDE: That's it. See? We have to have
15 a quorum to do these important things.

16 Okay. So the next item that we have -- and it's good
17 that we're starting just a little bit early on this because
18 I have a feeling 30 minutes won't be enough for the
19 conversation, which is every time we've started to address
20 the disparities issue, it's generated lots more
21 conversation. And you all really raised the disparities
22 issue in a way that was timely with the development of the

1 Office of Behavioral Health Equity.

2 So Lark's done a whole lot of work at thinking about
3 that and also, with, as I said earlier, before Lark got
4 here, she's working with a team of people across SAMHSA. So
5 it may seem like it's only one-tenth of Lark, but it's
6 actually one-tenth of Lark with a bunch of other folks. And
7 it's embedded now into all the strategic initiatives and
8 other work.

9 So, Lark, I don't know if you need to be up here or you
10 want to sit there. It should be showing at both these
11 screens.

12 MS. LARK HUANG: I can sit here. And how do I forward
13 the slides from here? Do I just say, "Forward"?

14 FEMALE SPEAKER: --

15 MALE SPEAKER: See if it'll reach.

16 MS. LARK HUANG: Okay. Oh, it works. Okay. So this
17 one right here?

18 FEMALE SPEAKER: Uh-huh.

19 MS. LARK HUANG: Okay. Thanks. It's exciting to
20 actually have an office to really do this. And it is my
21 left hand that leads the office. That's a part of me. And
22 that's my dominant hand. So anyway, this office of Office

1 of Behavioral Health Equity was created as a provision in
2 the Affordable Care Act. And it was a provision that
3 applied to six of the optives in HHS. And they're listed up
4 there.

5 They were to create an Office of Minority Health,
6 appoint a director who reports directly to the agency. And
7 the directors of these offices are coordinated out of the
8 Office of the Assistant Secretary for Health. And the
9 secretary was to designate an appropriate amount of funds to
10 each of these Offices of Minority Health from the agency
11 appropriations within the existing appropriations. And we
12 are required to report to Congress. We did a report
13 already. It was on the anniversary of the Affordable Care
14 Act and biannually thereafter.

15 As we look at this, establishing this office -- and
16 we're calling it Office of Behavioral Health Equity here as
17 we wanted to not just look at the disparities issues, but
18 what would also get us -- what would be the key pieces that
19 would get us to health equity for all of the different
20 populations who tend to be under-served, unserved or are
21 having poor outcomes in terms of health and behavioral
22 health.

1 We are embedded in a number of other entities going up
2 to the department with key policy drivers. So I wanted to
3 just kind of list some of those federal policy drivers that
4 help frame our work. And probably the overarching one is
5 the secretary's health disparities strategic action plan,
6 which I'll talk about later. And that's going to be
7 released April 8th.

8 A companion piece to that -- that was a federal plan in
9 terms of what federal agencies are putting out to do for the
10 year 2011. A companion piece to that was a national
11 stakeholders strategy for achieving health equity. And that
12 was a plan that was done through input of probably several
13 thousand people around the country participating in town
14 hall meetings that were convened by the department's Office
15 of Minority Health to get stakeholder input around some of
16 the issues in their communities around health disparities.

17 As I mentioned yesterday, AHRQ puts out a national
18 health disparities report. And in that report, we continue
19 to see disparities, particularly for Latino and African-
20 Americans around mental health issues. In the new Healthy
21 People 2020, there are some overarching disparity goals that
22 are in this version of the Healthy People Report. And then

1 the secretary has her strategic initiatives that the her
2 health disparities report is aligned with.

3 And then SAMHSA's eight strategic initiatives are also
4 a key driver for this office. And then we have four White
5 House executive orders pertaining to each one of the key
6 ethnic minority groups that has more to do with broadly
7 health, but also higher education. So they are efforts that
8 address the tribal colleges and universities and what's our
9 involvement with that, the historically black colleges and
10 universities, the Hispanic Surveying Institutions and the
11 Asian-American Surveying Institutions. So with that, if you
12 think about that as sort of a frame of how we're thinking
13 about the drivers for this office.

14 I wanted to just share with you just some quick data
15 from the AHRQ report, which really puts out their report
16 based on a lot of data from federal surveys. And I think
17 they are broken out by the race/ethnic groups along the
18 bottom as well as the far right one is by income level. And
19 I think the thing to really look at is the green bars. The
20 green bars show where things are worsening. And this is
21 broken out by several indicators of quality care, several
22 indicators of access to care.

1 And if you just look at the time frames, 2000, 2002,
2 2005 to 2007, and then if you look at 2009, you see a
3 tremendous increase in those green bars. So things are not
4 necessarily getting better around health disparities for
5 these populations. But, in fact, they're getting worse.

6 Okay, in terms of the secretary's actions, I mentioned
7 in her strategic initiatives, in her transforming the health
8 care system, she has an initiative around ensuring access to
9 quality, culturally-competent care for vulnerable
10 populations. You know, I think this is really one of the
11 first times I've seen culturally-competent care coming out
12 of this secretary's plan. She has a strategic action plan,
13 which was put together by a very senior work group and led
14 by the assistant secretary for health as well as the
15 director of ASBE. So this was led at pretty high-level
16 positions to really think what should be the strategic
17 action plan for 2011.

18 She's also created a coordinating council across the
19 different agencies with high-level representation to look at
20 LGBT issues at DHHS. So first time we've really seen a
21 coordinating council in the department to look at lesbian,
22 gay, bisexual, trans-gender issues.

1 And then the issues of social determinants is also part
2 of her plan in thinking and broadly, this administration's,
3 in terms of really looking at some of the other policies
4 that are not specifically health policies, but have health
5 implications. So we're a part of a number of different
6 administration -- actually, White House-led activities
7 around neighbor revitalization and looking at how do you
8 look at the housing issues, the transportation issues, the
9 health, the behavioral health issues in communities and put
10 them together in a place-based way that will sort of address
11 all of the agency's outcomes or the department's, including
12 the health and behavioral health.

13 And they have an urban cities initiative as well and a
14 communities solutions, which is the newest one. I don't
15 even know exactly what that one is yet. But all of this is
16 trying to really pull together what the various risk factors
17 that different departments address that can come together to
18 produce healthier communities.

19 Okay, so the secretary's strategic action plan to
20 reduce racial and ethnic health disparities -- this is just
21 a quick preview of kind of the overarching themes. Her
22 overarching priorities is really to look at assessing the

1 impact of HHS policies, programs to reduce disparities. So
2 there are action steps in there such as -- and these roll
3 out -- they cascade down to the individual agencies --
4 looking at, looking for and assessing health disparity
5 impact statements in our grants.

6 Another overarching priority -- and I think this has
7 come up here today and yesterday -- really looking at data,
8 use of data to improve the health of minority groups and
9 really looking at mapping what they're calling high-need
10 disparity areas and how that matches with HHS investments.
11 So they're putting that out as a department-led initiative
12 that also will begin to trickle down to us. We've taken a
13 little bit of start of that, as I mentioned before, sort of
14 doing some population mapping and where our investments are.

15 And then looking at measuring and incentivizing better
16 health care quality for minority groups. I'll preview --
17 there's a specific effort around SAMHSA. Each agency was
18 kind of looking at their condition, you know, how would
19 diabetes be tracked by CMHS. So the condition that was put
20 forward from us was depression. And so, how will SAMHSA and
21 CMS look at measures related to the burden of depression?

22 Ironically, in the Healthy People 2020 that's just come

1 out, the Institute of Medicine was asked to take a look and
2 identify the top 12 indicators for the country. And there
3 were categories both in mental health and substance abuse
4 there. So the mental health one had to do with depression.
5 And the substance abuse one had to do with binge drinking
6 and past month of illicit drug use. So it's, again,
7 exciting that some of our issues made it to the top 12 for
8 the Healthy People 2020 indicators. And this is the piece
9 that we would do in conjunction with CMS.

10 So and then here are some of her -- just to give you
11 some examples of her strategic initiatives and where the
12 action plan for disparities has action steps aligned with
13 her strategic initiatives. So she has a strategic
14 initiative to transform health care with a number of action
15 steps around that. Related in the disparities action plan
16 is really looking at improving health insurance coverage,
17 particularly for populations of color where we know they are
18 about 50 percent of the under and uninsured population,
19 establishing usual primary care providers.

20 We, again, know, particularly for under-served
21 communities, their primary care providers are often
22 emergency rooms as opposed to a stable kind of medical home

1 -- I'm sorry, health home. A second one of her strategic
2 initiatives is strengthening the health and human service
3 infrastructure and workforce. So specific action items in
4 her initiative, actually, also in the Affordable Care Act,
5 was really promoting the use of community health workers.
6 And specifically named were promotorez, looking at the
7 capacity of -- we've also contributed some for the action
8 steps around improving the capacity of practitioners and
9 integrated primary care behavioral health settings.

10 And Dr. Clark and I were just in discussions with HRSA
11 around that earlier this week -- improving our training
12 around trauma issues and looking at some of the existing
13 networks we already administer or convened such as our
14 historically black college and universities, or HBCU network
15 of the 105 HBCUs and what are the workforce training efforts
16 we could put in there as well as our national network around
17 eliminating disparities.

18 So if you can see the frame, it comes from the
19 secretary, comes -- you know, cascades down to us. And then
20 we look at how it diverges -- I'm sorry, converges with our
21 strategic initiatives and the secretary's and her action
22 plan to come up with action steps that are doable for us in

1 2011.

2 The stakeholder strategy plan -- I mentioned that. Her
3 plan is a federal plan. The companion plan was built up
4 from the ground among community stakeholders. These are
5 their five categories that they pulled out from their
6 various listening sessions around the country. And they are
7 action steps in each one of these particular domains.
8 There's probably quite a number of action steps in each of
9 those domains.

10 Okay, so what does that mean for what we think about in
11 terms of our own office here? And this is draft. You know,
12 we're still in process of development and certainly, you
13 know, welcome your input around it. Our vision: all
14 populations have equal access to high-quality behavioral
15 health care. Our mission: Our mission sits within the
16 overarching SAMHSA mission to reduce the impact of substance
17 abuse and mental health -- I'm sorry, mental illness on
18 populations that experience behavioral health disparities by
19 improving access to quality services and supports that
20 enable these individuals and families to thrive, participate
21 in and contribute to healthy communities.

22 We thought it was important in our mission to look at

1 the access, the quality and the outcomes issues at multiple
2 levels at individuals, families and communities because we
3 think when we're looking at these populations, their
4 outcomes are definitely intertwined with the health and the
5 access and the assets and the issues going on in their
6 communities.

7 Some of our functions: leadership issues around health
8 equity issues, health disparities issues, you know, what we
9 do as an office in terms of identifying and linking. It
10 doesn't mean we have all the leadership capacity within the
11 office at all. But it's certainly spread throughout SAMHSA
12 and our partners. And how do we bring that together in a
13 meaningful way?

14 Disparities policies and practice: Again, if you think
15 about the action steps in the secretary's plan, we need to
16 think about disparities, impact statements in our own grant
17 programs. We are -- why I've been in and out of here, we
18 are looking at our phase right now. And we're looking to
19 make sure that some of the OBHE issues are addressed in our
20 SAMHSA RFAs as we're in process of developing them and
21 hopefully getting them out the door really soon.

22 I'm looking at action steps within each of the SAMHSA

1 strategic initiatives. And so, we, as our small work group
2 across the agency related to the OBHE, really went through
3 each of the strategic initiatives, work with the leads on
4 those, talk to them about issues around health equity and
5 disparities issues to make sure that some of those are also
6 included in their action steps.

7 Hortensia, you just mentioned the IOM military piece.
8 And we had data around there around the over-representation,
9 particularly of Native Americans, Latinos and African-
10 Americans in the lower ranks also of the military. So
11 they're more vulnerable to casualties. And that's so you
12 get them at higher rates. And how do we address those
13 issues there within the military agenda?

14 The work with Fran around the suicide prevention piece
15 and had a joint meeting with CDC to address specifically
16 Latina youth suicide and tribal youth suicide. You know?
17 How do we make sure that those are a part of our prevention
18 activities there?

19 With John, we've talked about, well, how do we do
20 strategies and outreach and enrollment, given the high rates
21 of uninsurance in these populations and not even knowing
22 where to go to get enrolled or how to do that. And CMS

1 actually has a lot of really good in-language publications
2 around that. So that's an example of how we're looking at
3 our strategic initiatives and calling out the action items
4 that we would contribute to and monitor.

5 Data strategy: And as we speak now, at 10:30, there is
6 our first meeting of our data strategy work group within
7 OBHE that we're working with Pete's shop on, you know, what
8 should be the data issues that we want to look at within
9 this office. One of the things that in -- I served on the
10 Health Disparities Council. And we fed into the Data
11 Council that's at the department and really trying to get
12 some kind of standardized collection of race, ethnicity and
13 sexual minority status identifiers.

14 We don't do a good job of it across federal surveys.
15 It comes out in all different kinds of identifiers, even
16 though we have an OMB directive around that. And so, now we
17 have an Institute of Medicine report that ARC paid for to
18 give us ways of standardizing it, what should be
19 standardized categories that's sort of the gross, large
20 population level and then the granular-level categories
21 within Latinos, within Asian-Americans, within African-
22 Americans. And so, since that is now an IOM report, that

1 gives us a very good frame for how we might systematically
2 think about collecting that data in our GPRA data in our
3 grants data so that we can say, how many we're serving, how
4 we're serving, what their outcomes are, what our penetration
5 rate is in different populations.

6 And then Pete's already done, I think, a very good job
7 of putting out short reports on different population groups.
8 And we'd like to work further in terms of systematically
9 getting a series of reports out, you know, on the different
10 populations.

11 We actually have one of our programs that's actually
12 testing LGBT identifiers in their evaluation in their GPRA
13 data. So we're a little bit ahead of the department,
14 although we have also have an interagency agreement with CDC
15 to do some testing around LGBT items in national surveys.

16 And then we are also developing a communications
17 strategy with Mark's shop, the Office of Communications, on
18 a number of ways, both in terms of our public awareness
19 campaigns. How do we better -- get better penetration of
20 our campaigns into communities that are either mono-lingual
21 and not in English or still don't necessarily get access to
22 our general population -- general public awareness

1 campaigns. And so, we have worked with Mark, and we have
2 four different campaigns for each of the ethnic groups that
3 have recently gone out. And we're excited about that.

4 We launched our African-American Black Pain and
5 Depression, actually, at Howard and had a very good uptake
6 of that. We are working with, again, Mark's shop on our Web
7 page, which we anticipate to be launched by April 12th,
8 which is when we have to do a report on our efforts to
9 Congress in person. So we're hoping that page is -- it's in
10 process right now. And we actually do have a blog that's
11 ongoing now.

12 And we're looking at our communications strategies,
13 both in terms of internal SAMHSA as there are a lot of
14 activities going on within each of the centers and offices.
15 We look at external groups that we connect with and also
16 federal work groups. So our communications strategy has
17 multiple throngs and multiple direction.

18 Sorry, wrong button. I'm not really good at this. I
19 could never do that, spin your hand in different ways,
20 direction and things. Okay, five.

21 Okay. And then we also look at our office as a support
22 and resource for customers. And we think of customers as

1 internal and external SAMHSA. We look at our customers as
2 our own staff here first in terms of if resources are needed
3 around cultural issues. Not that we have all them, but we
4 do a linkage piece. And we can bring experts in.

5 We look at resources. We get requests externally now
6 that we are a stated office, you know, around cultural
7 competence assessment measures, you know, or how best to use
8 certain identifiers for different populations or, you know,
9 what does our data look like. We get requests on can we
10 look at and screen documents coming up from the centers
11 around how we address some of the cultural issues
12 appropriate. So we look at ourselves as also having a
13 number of different customers that we want to serve as well
14 as we can.

15 We also look at where we pull together critical and
16 emerging documents so we have a "must reads" on our Web
17 page, which includes this report I just mentioned on
18 standardizing race/ethnicity data, a report that is being
19 released today, the IOM report on LGBT health. As we're
20 looking at health reform, we have an excellent document put
21 out by the Joint Center, which is the African-American think
22 tank in D.C., really looking at advancing health equity for

1 race, ethnic diverse populations.

2 We've gotten a lot of questions about health reform
3 issues and talk about that with John. And we both refer
4 people to this document. We have a new report from AHRQ on
5 health care costs and utilization project, which is looking
6 at state documentation of race, ethnicity, health
7 disparities to then inform states developing their strategic
8 actions and a recent report on CDC on health disparities.
9 So we look at it as a way -- and we're trying to set up this
10 Wiki knowledge page where you can not go -- have to search
11 through a lot of intense, extensive data systems, but you
12 can look up through Wiki pages and kind of see what you want
13 to look at more readily.

14 And our sixth function is this quality practice and
15 workforce development piece where we are trying to look at
16 how can we increasingly build the workforce in these
17 communities that increasingly wants to know about what works
18 for their communities, what do we know about evidence-based
19 interventions and capturing what they have identified as
20 what works as the employee programs in their communities.
21 So it's really bi-directional.

22 We know that there are communities that are doing

1 terrific work around integrating care or doing suicide
2 prevention for tribes. We want to learn what's going on
3 there so other tribes or other communities don't have to
4 reinvent the wheel. So we have this national network to
5 eliminate disparities in behavioral health, which we call
6 the NNED, which is seeded by Sam Sarebach. She had more
7 funding coming in from NIH and foundations once we seeded
8 it. And so, now we have over 700 community-based
9 organizations specifically serving race, ethnic and minority
10 and LGBT populations and are doing a lot of networking and
11 resource sharing.

12 We have communities of practice that have -- several
13 that have been launched to work on the through virtually
14 training and training and coaching, picking up evidence-
15 based interventions as well as learning communities around
16 that.

17 This is -- before we consolidated our Web pages, this
18 is the NNED's Web page. And it's a work page. We do a lot
19 of interaction with communities on this. One of our
20 communities of practice is our coaching supervision through
21 shared platforms on this site as well as our learning
22 customers. It's a well-served, very timely resource

1 information on this network.

2 Seventh, we will do and continue to do some special
3 projects with centers, whether it's disparities policies
4 summit that's coming up in May through CMHS. We have the
5 grantees access the NNED, can be part of the community, the
6 learning conference. Although I should say the NNED is not
7 just grantees. In fact, it's beyond our grantees. It is
8 community-based organizations that are not necessarily
9 looped in to the grant making efforts here.

10 And then proposed special projects. And we're really
11 interested in looking at depression, which in some of our
12 population, particularly African-American women population,
13 low-income, is about three times the national rate of
14 depression in those communities.

15 We are connecting with other SAMHSA work groups that we
16 have that address specific populations. So within LBHE, we
17 work with the Pacific Jurisdictions work group, the Tribal
18 -- Sheila's Tribal Issues work group. We have a work group
19 on sexual gender and minority interest groups. We have a
20 broad, cross-agency Cultural Competence and Eliminating
21 Disparities work group, Wes' CSAT stakeholder groups and
22 CMHS' Eliminating Mental Health Disparities work group. So

1 we're not doing their work, and we're not taking over their
2 work. We're only linking and making sure that we're looking
3 at this as kind of one SAMHSA.

4 And we're also building our capacity of our own SAMHSA
5 staff through training and in-services. And on one of our
6 tribal learning efforts, we brought in tribes and different
7 programs to tell us about what they were doing. And they
8 were less excited about traveling here and telling us what
9 they were doing than the fact that our staff wanted to
10 learn. And that was just very exciting, I thought.

11 And we definitely want input. And actually, as we
12 structured this, we've taken some of your input, both around
13 what we should see in the strategic initiatives from that.
14 So that's very critical to us. And we're in the process of
15 developing our strategic plan with benchmarks and a tracking
16 mechanism.

17 So that's where we are on the office and very much open
18 to your ideas around directions, about our processes, how
19 you might want to be involved with us. We're very much open
20 to that.

21 MS. PAMELA S. HYDE: Thanks a lot, Lark.

22 Before I open it for discussion, because I know there

1 will be a lot, I just want to remind you of a couple things.
2 A lot of what Lark started out with is what we are directed
3 to do by Congress and the secretary and other things. When
4 that happens, Congress has its view about what populations
5 they want us to focus on. So they have, I think, mostly the
6 racial and ethnic minorities and mostly the four.

7 Right, Lark?

8 So we have to pay attention to those, in a way, because
9 Congress directs that. And then the secretary has
10 directions she gives that are based in part on White House
11 direction and in part on her own direction. And in some
12 cases, which is true for us as well, she has other efforts
13 that are going on in other places about things like women's
14 health, because there's an Office of Women's Health that is
15 separate, and then things like the LGBT population, which
16 has been brought in under this construct a little. So that
17 frames what we do.

18 And then I want to give Lark credit, but I totally
19 agreed with this. When we made a decision about what to
20 name this office, we explicitly named it the Office of
21 Behavioral Health Equity rather than the Office of Minority
22 Health because, while we don't have a lot of things in the

1 office -- it's literally Lark and a couple of other helpers'
2 little bits, we're trying to get some more staff-level help
3 there. But nobody gives us money to do any of this. They
4 just tell us to do it.

5 But there's also -- it's very clear Native Americans
6 don't want to be considered a minority. They have a
7 different legal relationship than might be encompassed in
8 that word. Women are not a minority in this country. So
9 that word doesn't work. LGBT folks are clearly a minority,
10 but just the very term "LGBT," there are a ton of different
11 issues among those four sub-groups, if you will. So Lark's
12 office has played a role in just sort of coordinating some
13 of that work.

14 So for some of this other effort, that might be
15 something SAMHSA cares about. We have a completely other
16 advisory committee about LGBT -- I mean, about women's
17 issues. And then you'll see programmatic issues. And Lark
18 mentioned a few of them. But there's programmatic issues,
19 especially about our concern about suicide among Latina
20 girls, youth, about pregnant and parenting women. We have
21 some explicit work that we're concerned about in the
22 military families initiative and the trauma initiative about

1 sexual -- or about sexual trauma, which has a
2 disproportionate impact on women and obviously, a
3 disproportionate impact on people of color and on tribal
4 members just because of the numbers.

5 When we started looking at the LGBT insurance issues,
6 as Lark said, what we realized is you really have to
7 separate that out. So the insurance rates among trans-
8 gender people is way low for lots of reasons. The insurance
9 rates among gay men is not so different than the general
10 population and so and so. So if you go on with that, it's
11 really a disparate group.

12 And then we do out of Pete's shop statistical reports
13 on the different groups that we have a concern about just to
14 put data out there about what the disparities are, to the
15 extent the data exists. And that's part of the issue about
16 where do we need data to say what these disparities are.

17 So my point is is for us, Behavioral Health Equity is
18 much broader than the congressional mandate or even in the
19 secretary's mandate. It's really for us looking across all
20 these issues, some of which is driven or directed or
21 coordinated out of Lark's shop and some of which Lark's
22 office relates to, like Sheila's work or Kana's role as the

1 Associate Administrator for Women's Services, et cetera. So
2 there's a lot going on here. And I just wanted to make that
3 clear before we open up the conversation.

4 All right. So what's your thoughts or reactions here?

5 I'll start with Flo and then Hortensia.

6 MS. FLO STEIN: Just a question. I see how the Healthy
7 2020 things roll up from the states. Do any of these
8 processes link to the Offices of Minority Health in states
9 so that we're kind of having a national agenda?

10 MS. LARK HUANG: Yeah, when the department's Office of
11 Minority Health did their stakeholder strategy report, there
12 are links in the states and sort of pulling together worthy
13 offices of minority health in the states. The problem that
14 we had with that perspective is that often state offices of
15 minority health don't necessarily look at the behavioral
16 health issues that we needed to augment that with behavioral
17 health respondents in that. But they do -- our department
18 Office of Minority Health does link, to a certain extent,
19 with some of the state offices of minority healthy. In the
20 past, we have done some work with the multi-cultural
21 directors in states that tend to be in the mental health
22 departments, not as much in the substance abuse side.

1 MS. FLO STEIN: Well, we have one in our division who
2 links to the state office. And they're really isolated.
3 They're out there kind of struggling to put together an
4 agenda, struggling with data.

5 MS. LARK HUANG: Yeah. Right.

6 MS. FLO STEIN: And it really might be something that
7 we could build on.

8 MS. PAMELA S. HYDE: A good example. Thanks.

9 MS. LARK HUANG: Yeah.

10 MS. HORTENSIA AMARO: So, Lark, fantastic as usual. I
11 really liked your presentation.

12 MS. LARK HUANG: thank you.

13 MS. HORTENSIA AMARO: I mean, your presentations are
14 always very informative. And I like the title. I think
15 bringing up the term "equity" is very timely. It's what's
16 being used now. And I think it puts attention on the real
17 issue that highlights the framework of social determinants.
18 So I think -- you know, I liked it very much.

19 So I have a couple of three points that I'm wondering
20 how you're thinking about these issues. So in health care
21 reform, we know that immigrants who have been here less than
22 five years don't have access to the benefits that other

1 people do, number one. Two, undocumented individuals don't
2 have access to any of it and won't get access to it unless
3 something changes.

4 And I'm wondering -- but inevitably, they're going to
5 show up in our system of care and probably more in the
6 agencies that SAMHSA is really most connected with because
7 they have no safety net. And so, I'm wondering how we're
8 going to document this because even though they're not
9 covered now, I think, you know, getting data will be
10 important. And I know that some of those issues are
11 sensitive, especially with people who are not documented.
12 But I think they're worth thinking about. So that was the
13 first point.

14 Second point has to do with the issue of language in
15 the requirements of Health Care Reform Act and collecting.
16 So I assume that we're going to be doing that and thinking
17 about how to best assess that. Or I suppose the secretary's
18 the one who's going to tell us how to do it.

19 MS. LARK HUANG: And that was one of the pieces in that
20 IOM report that talks language, race and ethnicity data.

21 MS. HORTENSIA AMARO: Sure. Right. Right.

22 MS. LARK HUANG: So that'll probably be the overarching

1 framework of how we collect it.

2 MS. HORTENSIA AMARO: Right. We just don't know
3 exactly, like, how it's going to be measured?

4 MS. LARK HUANG: Right.

5 MS. HORTENSIA AMARO: Okay. And then the last point --
6 you know, this issue of women versus minorities is one that
7 I think since I was a graduate student I've been struggling
8 with as somebody who's always been active in, you know, both
9 research and organizations related to gender issues and
10 related to communities of color. And this came out -- and
11 unfortunately, I don't think it's improved much -- that each
12 of those groups tends to address those issues specifically
13 and say, "Oh, we're not going to look at gender because
14 we're looking at," but they're really important intersects
15 between gender and those race and ethnicity that you totally
16 miss if you don't look at that intersect.

17 A great example is I was on the IOM Committee that
18 issued the report on women's health. And we saw it over and
19 over again as we reviewed that literature. So I'm hoping
20 that there's -- I'm sure you're cross-walking, you know,
21 your directives with so many other programs in SAMHSA or
22 offices that I'm sure you're going to cross-walk with the

1 group that's doing the work on gender and women's health
2 because that intersect gets missed a lot. And I hope we're
3 able to address that this time.

4 MS. LARK HUANG: We're cross-walking a lot.

5 MS. HORTENSIA AMARO: Yeah.

6 MS. LARK HUANG: And to the extent that we can, I think
7 when we look at certain -- you know, like, for example, if
8 we look at this depression effort, you know, we see a high
9 rates of depression among women, among women of color. So
10 we'll probably get at it that way. Exactly what we'll
11 cross-walk with here at SAMHSA, that's for me to discuss
12 with Kana and see what's coming out in terms of her strategy
13 around the women's issues. But we will certainly discuss
14 it. How it will look in terms of our action steps, I can't
15 tell you at this point.

16 MS. HORTENSIA AMARO: Yeah.

17 MS. LARK HUANG: But we'll do that.

18 MS. HORTENSIA AMARO: You know, when we looked at the
19 literature and then, you know, it's just been my
20 observation, every -- I'm 60 now, and I started doing work
21 like this when I was around in my twenties. And, you know,
22 in every situation, groups that tend to focus or even

1 studies that tend to focus on women, overwhelmingly -- there
2 are some exceptions -- tend to not, as you know, not focus
3 on the specific groups of women or have sufficient sample
4 sizes.

5 MS. LARK HUANG: Yeah.

6 MS. HORTENSIA AMARO: And then on the other side, race
7 and ethnicity groups that look at those issues tend not to
8 really pay enough attention to gender. So, I mean, I'd be
9 happy, you know, to talk to you more about ideas somehow.

10 MS. LARK HUANG: Sure.

11 MS. HORTENSIA AMARO: That could happen.

12 MS. LARK HUANG: That would be great. I mean, and then
13 on the other piece you mentioned, the immigrants and the
14 undocumented, I mean, that's a challenge.

15 MS. HORTENSIA AMARO: Yeah.

16 MS. LARK HUANG: I mean, I don't know how we're going
17 to get that data. I mean, I think it's kind of shortsighted
18 in a sense. Those people are going to end up in emergency
19 rooms. So the costs will be there. But any thoughts you
20 have around that, you know, we'd be happy to discuss with
21 you.

22 MS. HORTENSIA AMARO: We can talk about that, yeah.

1 MS. LARK HUANG: Okay.

2 MS. PAMELA S. HYDE: Let me just throw in a reality
3 piece on this one. If you aren't following the
4 conversations in Congress about budget reductions, one of
5 the things that the -- at least the newer folks in the House
6 who feel very strongly about specific subject areas for
7 cuts, not just the amount of cuts, but one of them is any
8 and all expenditures around anything having to do with
9 undocumented individuals. So I don't think that will carry
10 the day.

11 But nevertheless, that, along with things like Planned
12 Parenthood and, you know, some of these highly charged
13 issues that have direct impact on either people of color,
14 women or other kinds of groups that we might have some
15 concerns about are explicit areas that some congressional
16 leaders are saying we don't want to spend any money there
17 ever, nada, nothing, nada, which is shortsighted.

18 As having sat in a state and had responsibility for
19 Medicaid, I can tell you that people come to the door,
20 whether you let them sign up or not.

21 MS. HORTENSIA AMARO: That's right. That's right.

22 MS. PAMELA S. HYDE: And then you have to figure out

1 what the cost to Medicaid is for that. And people don't
2 want to look at it that way, but they do.

3 MS. HORTENSIA AMARO: Yeah.

4 MS. PAMELA S. HYDE: All right, Stephanie, I think you
5 were next.

6 MS. STEPHANIE LEMELLE: Sounds like a terrific
7 department. And I've been looking for a garden to plant a
8 seed. And I've actually spoken to a whole bunch of folks
9 about this particular seed that I want to plant. And it has
10 to do with policy and practice and, in particular, has to do
11 with the use of the drug, clozaril, which is an anti-
12 psychotic medication that's used as a sort of last resort
13 medication. But it's often the best medication for people
14 who are treatment-refractory.

15 And it's been shown, particularly for folks who were in
16 long-term hospitals, in state hospitals that once they were
17 put on clozaril, they were able to be discharged. The
18 problem with clozaril is that it can lower your white blood
19 cell count. And so, there are parameters that the FDA has
20 set up using a standard white blood cell count and that if
21 you are below the standard, you're not eligible to use
22 clozaril.

1 And there are specific minority groups, including
2 African-Americans, people of African descent and some Latino
3 populations that at normal baseline have lower white blood
4 cells counts. And it's called benign ethnic neutropenia.
5 So they're not eligible to even go on a trial of this
6 medication because of the FDA standards on it. So I think
7 this would be a great opportunity for SAMHSA to have a
8 targeted project of looking at the data that's out there on
9 this.

10 And I can tell you that in Europe, in many parts of
11 Europe, they've established two baselines. There is the
12 regular baseline, which is primarily based on, as we know,
13 white men, because they're the ones who participate in a lot
14 of these clinical studies. And they have a minority
15 baseline. So for people who have a chronically low white
16 count, they're using this other standard.

17 We have not adopted that in the United States yet. And
18 so, it might be something worth looking into. And I'm not
19 sure -- I've been trying to check which garden to plant this
20 in, but maybe your garden is the right one.

21 MS. LARK HUANG: Well, my garden is really little right
22 now. But it's kind of a lot of weeds I'm clearing out

1 still.

2 [Laughter.]

3 MS. LARK HUANG: But in our NNED, one of our members, a
4 leading member, is an ethno-psychopharmacology center in San
5 Francisco. So we might want to see how we might link up.
6 And maybe they've done some work around that, too. Yeah, so
7 we'll talk.

8 MS. PAMELA S. HYDE: Do you want to add to that, Wes?
9 Did I see you about to punch your button?

10 MR. WESTLEY CLARK: I wanted to remind you that the FDA
11 does have an office that deals with these issues. So it
12 would be a matter of collaboration since the FDA has a
13 little more staff than you do.

14 MS. LARK HUANG: And I think, Wes, that's a great point
15 because all of FDA has set up a new office with a ton of
16 staff. And so, it could be something that we meet monthly,
17 all the directors. So it could be something that we did
18 have an exchange about, too. Yeah.

19 MS. PAMELA S. HYDE: Well, great.

20 MS. STEPHANIE LEMELLE: I think, also -- I'm sorry.
21 Maybe involving the APA as well because I've been told that
22 they have a representative that's in touch with SAMHSA as

1 well. So maybe getting them involved would be helpful.

2 MS. PAMELA S. HYDE: As I said earlier, you're going to
3 hear a presentation later on something that Stephanie
4 brought to us, which was pretty direct and clear we could do
5 something about. And she and Fran and others have been
6 working on it. So these are the kind of things that are
7 pretty concrete we can get done.

8 Save the world is a little harder. It takes a little
9 bit longer. But we get there, too.

10 MS. CYNTHIA WAINSCOTT: I suggest if we're going to
11 have that discussion, we get some representative of the
12 consumer community at the table at the same time.

13 MS. PAMELA S. HYDE: Good point, Cynthia. Thank you.
14 That's a good point.

15 All right, any other comments around from the Advisory
16 Committee about this?

17 All right, Lark, thank you very much. I think the
18 timing was good on your input about our strategic
19 initiatives and what's coming out of Congress and the
20 secretary's office and our own interest in this area. And
21 I'll add my thanks, Lark, to Hortensia's. You always do
22 terrific work. So thank you very much.

1 All right, we're going to move next to a break. We are
2 literally right on time, so we want you to keep us on time
3 by coming back and being ready to start again right at 5
4 'til 11. Thanks.

5 [Break at 10:40 a.m.]

6 [Reconvene at 10:55 a.m.]

7 MS. PAMELA S. HYDE: All right, let me just make one
8 comment that somebody reminded me about. I highlighted this
9 morning that the Women's Services Committee and the Tribal
10 Committee are meeting this afternoon because those issues
11 came up yesterday. But obviously, if you don't know, each
12 of the centers, each of the three centers' advisory
13 committees are also meeting this afternoon, so if any of you
14 have an interest in any one of those centers' issues. And
15 if you don't have the agendas for any one of those and you
16 want to see what they're going to be dealing with, then
17 these folks over here can get you copies of those agendas.
18 Okay? Or the heads of the centers can get you copies of
19 those agendas, whatever works for you.

20 All right, let's go next to Extended Nicotine
21 Replacement Therapy. This is something that Stephanie
22 brought to us and that she and Fran have been working on it.

1 So I'm going to turn it over to them to do a quick
2 presentation. And then we'll have a little bit of comment
3 about that.

4 MS. STEPHANIE LEMELLE: I guess I need the clicky-
5 clicky. Oh.

6 MALE SPEAKER: It's a mouse.

7 MS. STEPHANIE LEMELLE: All right. Let's see if I can
8 handle that. Good. Okay.

9 So, yeah, so this was an issue that I raised with
10 SAMHSA. And so, SAMHSA, in conjunction with the CDC,
11 decided to petition the FDA to see if we could get changes
12 in the regulations on nicotine replacement therapy. So why
13 are we doing this?

14 Obviously, tobacco use is very, very common. It's the
15 leading cause of death and disease in the United States, 443
16 deaths a year from tobacco-related illnesses. One-fifth of
17 all adults in the United States smoke cigarettes. The rates
18 for children and for youth are actually going up, even
19 though the rates for adults seem to be going down in general
20 trends. But for kids, it seems to be going up.

21 There were lots of surveys that were done looking at
22 tobacco use. And people with mental health issues are two

1 to three times -- have a two to three times higher rate of
2 use of tobacco. And when they use tobacco, they tend to be
3 heavy smokers. And in this case, we're talking specifically
4 about cigarette smoking and not chewed tobacco or other
5 tobacco forms. But they tend to be heavier smokers with
6 two-plus packs per day.

7 And in the study -- and I think this was mentioned
8 yesterday -- that people with severe mental illness are
9 dying 25 years younger than the average general population.

10 And one of the major contributing factors to this, and
11 preventable factors, is cigarette smoking.

12 There was a public health study that showed that the
13 use of tobacco cessation techniques can really help to
14 reduce people's use of tobacco and that there are other --
15 besides using medications, there are also therapeutic
16 interventions that can help to reduce tobacco use. And by
17 using these, that you can actually increase people's chance
18 of actually quitting cigarette smoking.

19 Cost-effectiveness, which is always something that we
20 have to pay attention to -- the risk factors and the
21 morbidity associated with cigarette smoking is tremendously
22 high, with cardiac disease, vascular disease, cancer risk

1 factors, all of which -- thank you for the chocolate -- all
2 of which are much more expensive than the cost of using
3 nicotine replacement and other treatments, cessation
4 treatments. And so, in terms of the cost-effectiveness,
5 it's actually much cheaper to take this approach to the
6 problem.

7 So nicotine replacement therapy -- the Food and Drug
8 Administration has approved seven different types of
9 medications used to treat tobacco cessation. Five of these
10 are nicotine replacement treatments. And they specifically
11 are substituting nicotine in a purer form than you would get
12 in cigarettes or in other tobacco medication -- tobacco
13 uses. The FDA has approved nicotine replacement therapy
14 usually for 6 to 12-week intervals. And the average
15 population, people who use nicotine replacement therapy, can
16 be weaned off of cigarettes and can actually be successful
17 at quitting in 6 to 12 weeks.

18 However, there's other studies that have shown that, in
19 some people, that's not enough time. And in particular,
20 with people with severe mental illness, it's clear that they
21 need more than the average dose of nicotine replacement
22 therapy and for longer durations. And again, the problems

1 with smoking are not the nicotine. The problem with smoking
2 is the tobacco and the other chemicals that are in
3 cigarettes. If you give someone pure nicotine, it actually
4 doesn't have any harmful effects over long periods of time.

5 So again, with folks with severe mental illness,
6 nicotine and nicotine replacement needs to be at a higher
7 dose and for longer periods of time for them to be
8 successful. And part of the reason why we think it's so
9 difficult for people with severe mental illness and mental
10 illness in general to come off of nicotine is that nicotine
11 actually enhances their attention and makes them feel
12 better. It makes them less anxious, in some cases, improves
13 their cognition.

14 And there may be other effects, particularly in the
15 sub-population of people who suffer from schizophrenia, that
16 there may be other effects of nicotine that actually are
17 positive effects. And so, taking them off of cigarettes
18 really may have a deleterious effect on their cognition and
19 on their quality of life. And often people with severe
20 mental illness are considered to be self-medicating by using
21 nicotine in this way, to treat these underlying deficits,
22 which may be related directly to their illness, or it may be

1 related to the side effects of some of the medications that
2 we give them.

3 So again, people with mental illness tend to be more
4 dependent on nicotine. And there have been lots of studies
5 that have shown that they score higher on some dependency
6 scores and dependency ratings. The other issues -- and I
7 keep harping on Clozapine. It's one of my favorite drugs.
8 But Clozapine is just one example of many psychotropic drugs
9 that are affected by the blood levels of nicotine and the
10 receptor binding of nicotine. And so, for example, when
11 people are hospitalized, in most hospitals now nationally,
12 they're not allowed to smoke. And so, people withdraw from
13 nicotine in the hospital setting. And they're started on
14 medications whose doses and concentrations are affected by
15 the absence of nicotine.

16 And once the people are discharged from the hospital,
17 most people will go right back to smoking. So once they
18 start smoking again, their nicotine levels rise, and it
19 tends to drop the drug levels of a lot of the medications
20 that they're given on the in-patient units. So blood levels
21 that are drawn on in-patient hospitalizations may differ,
22 both higher and lower, than blood levels in the outpatient

1 setting when people are smoking. So there's another reason
2 why we need to pay attention to the nicotine replacement.

3 So in general, nicotine is prevalent in the population
4 of people with severe mental illness. The morbidity and
5 mortality of cigarette smoking is high, but it is
6 preventable, that nicotine replacement therapy works in this
7 population. But people tend to need much higher doses and
8 for much longer periods of time. And one of the theories
9 now is that they may need to remain -- people with severe
10 mental illness, particularly with schizophrenia, may need to
11 remain on nicotine replacement indefinitely because of the
12 positive effects that the nicotine has on their cognition.

13 And for these reasons, we wanted to petition the FDA to
14 change the regulations on the nicotine replacement. And in
15 order, obviously, for Medicaid to cover it and for other
16 insurances to cover it, we need to get the FDA to change the
17 requirements on nicotine replacement. Okay.

18 MS. PAMELA S. HYDE: So again, open the conversation on
19 this. The thing that was particularly interesting to us
20 about this was it was fairly important, but low-cost policy
21 change that would need to take place among several agencies
22 that two of our partners, ourselves and CDC and others might

1 agree to. But it would take action from two other partners
2 in order to make some difference here. So this is something
3 that we could take a look at and do something about in
4 partnership with other players without having to have a big
5 grant program to make it happen. And so, we really
6 appreciate Stephanie bringing this forward.

7 So do people have conversation or comments about this?

8 I'm sorry. Go ahead. Can you hit your button there?

9 MS. HORTENSIA AMARO: Oh. So that was very
10 interesting. I learned something. Thank you for presenting
11 that.

12 My question was about are there any special
13 considerations or issues that need to be considered in terms
14 of pregnant or lactating women?

15 MS. STEPHANIE LEMELLE: Yeah, absolutely. I mean, I
16 think, again, the effects of nicotine in the general
17 population are varied. In some populations, particularly
18 women that are on birth control pills, there's -- you know,
19 it's associated with a risk of blood clots and other issues.

20 MS. HORTENSIA AMARO: Right.

21 MS. STEPHANIE LEMELLE: So I think that, you know,
22 again, this really needs to be done in collaboration with a

1 physician who's monitoring all of the different aspects of
2 someone's health. And it's not something that -- I mean,
3 you don't want to add a medication to someone's medical
4 regime if you don't need to.

5 And I think that it's more specific to folks who have
6 had difficulty trying to quit who aren't at risk for other
7 issues, who aren't pregnant, who aren't on birth control.
8 Or if they are on birth control, are being monitored closely
9 for that.

10 MS. HORTENSIA AMARO: And is your recommendation -- I
11 mean, you stress schizophrenia a lot, but is this something
12 that you think applies more broadly than that? I mean,
13 what's the population that it would apply to that would have
14 the kind of physiological impacts that you mentioned?

15 MS. STEPHANIE LEMELLE: The studies have about the sort
16 of cognitive effects of nicotine have really been done
17 particularly with people with schizophrenia.

18 MS. HORTENSIA AMARO: Right. Yeah.

19 MS. STEPHANIE LEMELLE: I think that the difficulty in
20 quitting smoking is something that's broader and goes beyond
21 just people with -- I mean, I think it applies to the
22 general population, for sure.

1 MS. HORTENSIA AMARO: Yeah.

2 MS. STEPHANIE LEMELLE: But I think that often people
3 with schizo-affective disorder, people with other severe
4 forms of mental illness may have difficulties. And it could
5 be related to the benefit that they get from the use of the
6 nicotine.

7 MS. HORTENSIA AMARO: Uh-huh. Yeah.

8 MS. STEPHANIE LEMELLE: And so, the real issue is that
9 the guidelines really are very tight. And because the
10 guidelines -- or the funding is sort of driven by the
11 guidelines, that insurance companies and Medicaid won't
12 cover longer term or higher dose use.

13 MS. HORTENSIA AMARO: Right. Yeah. Thank you.

14 MS. PAMELA S. HYDE: Part of the issue here, Hortensia,
15 just to clarify a little bit, is that people with
16 schizophrenia have among the highest, if not the highest,
17 use of cigarettes. So even all the numbers that show mental
18 -- people with mental health issues and substance abuse
19 disorders use cigarettes at higher levels than the general
20 population. But this population is even higher yet. And
21 then the interaction with the particular medication for that
22 particular diagnosis is part of the issue as well.

1 MS. HORTENSIA AMARO: So it's specific to that
2 diagnosis that you're --

3 MS. STEPHANIE LEMELLE: No, I don't think it's specific
4 to schizophrenia. I think it's a general adaptation of the
5 policy for people with severe mental illness, which would
6 include schizophrenia and schizo-affective disorder. I
7 don't know that there have been studies done with folks that
8 have bipolar disorder, but certainly, folks that have
9 schizophrenia and schizo-affective disorder.

10 MS. PAMELA S. HYDE: So actually, what we're doing
11 about it -- and, Fran, I don't know. You may want to make a
12 comment about what we're doing about it. But the point is
13 if we don't get FDA to allow a longer use, that means
14 Medicaid can't pay for a longer use. And so, doctors don't
15 even have the ability to talk to patients about it if we
16 can't get that higher -- so, Fran, do you want to say just
17 two words about what we're doing about it?

18 MS. FRANCES HARDING: Yeah. The two words are that Pam
19 and Dr. Frieden at CDC have put together -- we've put
20 together -- they're going to cosign a letter that is going
21 to go to the FDA within the next couple of days. The letter
22 has finally been approved by both agencies at Pam's and Dr.

1 Frieden's level and is circulating through staff here at
2 SAMHSA. And we expect, within two weeks or so, that this
3 letter will go out, which is such a big feat for us and very
4 grateful to Stephanie and Ursula -- Dr. Ursula Bower and CDC
5 because we haven't really worked together like this. So the
6 fact that this letter will go with both Pam's and Dr.
7 Frieden's signature, we hope, will make a big impact and
8 start a conversation.

9 MS. PAMELA S. HYDE: And we'll reach out to Peggy
10 Hamburg, who's head of FDA on a personal level, too. But we
11 want to put this in writing so it's a public statement about
12 our position about that.

13 All right, I saw a couple hands.

14 I think, Kathryn, I saw your hand and then Arturo and
15 then Cynthia. Yeah.

16 MS. A. KATHRYN POWER: Thanks, Stephanie and Fran, for
17 this. This is, I think, a tremendous step in the right
18 direction. And one of the things that I think on an
19 evolution sense that the individuals with serious mental
20 illness, the states really started looking at state
21 psychiatric institutions and having smoking cessation
22 programs and making them no smoking zones and all those

1 kinds of things many years ago. And then the other wellness
2 and other campaigns have come forward.

3 I think one of the things that we could do is to take a
4 look at the state mental health authorities and substance
5 abuse authorities and let them know that these findings very
6 clearly show that individuals with co-occurring disorders
7 and serious mental illness in particular, that this extended
8 nicotine replacement therapy should be in their individual
9 treatment plans, which I think would be really a good
10 connection back to the providers and the physicians, if we
11 can include it in an individual treatment plan and then move
12 that forward in very deliberative ways about hosting that
13 kind of therapy within the agencies.

14 MS. STEPHANIE LEMELLE: I think that's absolutely true.
15 And I think that, you know, it sort of came to my awareness
16 as a clinician. And patients, you know, often folks that
17 were hospitalized were suffering because they're
18 withdrawing. And it wasn't being addressed in an aggressive
19 way.

20 And using the normal doses of, you know, the nicotine
21 patch, for someone's who's smoking upwards of two to four
22 packs of cigarettes a day, giving them a nicotine patch is

1 not going to in any way reduce their craving or their
2 withdrawal effects of the nicotine. And so, I think that on
3 a clinical -- for a clinical reason and to reduce people's,
4 you know, suffering, that it's something that needs to be
5 addressed on that level.

6 MS. PAMELA S. HYDE: Arturo?

7 MR. ARTURO GONZALES: Question and a couple comments.
8 You mentioned specifically schizophrenia. And would this be
9 effective for bipolar-affected individuals?

10 MS. STEPHANIE LEMELLE: Right. That's what --

11 MR. ARTURO GONZALES: No, I know that. But I guess I'm
12 wondering will the letter say specifically for
13 schizophrenic, or is it going to include other -- these
14 other individuals, like bipolar?

15 MS. STEPHANIE LEMELLE: If I'm not mistaken, the letter
16 is written in a general way. It does mention people with
17 schizophrenia specifically. But I think it also says people
18 with severe mental illness in general. So I think it's
19 inclusive of everyone.

20 MR. ARTURO GONZALES: Okay.

21 MS. STEPHANIE LEMELLE: It's not targeted just towards
22 people with schizophrenia.

1 MR. ARTURO GONZALES: So that would help then. Then
2 the other thing is let's say -- well, also, Pam, I was
3 wondering. Do you need any -- would it help -- you may not
4 need anything from this committee. But do you want anything
5 formally from this committee endorsing this or to help your
6 letter or anything?

7 MS. PAMELA S. HYDE: That's a good question, Arturo. I
8 don't think at this point we need it because normally
9 speaking, among operating divisions, we don't have
10 disagreements, certainly, not public disagreements. But not
11 working together is a different and more benign problem than
12 just flat out disagreements. If we get to a point where
13 there's anything like a public comment period or anything
14 like that, we'll certainly let you know. And, in fact, that
15 reminds me. There is a public comment thing coming out that
16 you should be aware of, but not at this point. But thanks
17 for asking that.

18 MR. ARTURO GONZALES: Well, maybe we should -- if you
19 would need it, maybe we should go on record so that you
20 already have it that we endorse -- that the National
21 Advisory Committee endorses SAMHSA's recommendation and work
22 on this in this area so that you have that.

1 MS. PAMELA S. HYDE: Do I take that as a motion?

2 MR. ARTURO GONZALES: I'll make it a motion.

3 MS. PAMELA S. HYDE: Do I hear a second?

4 MS. CYNTHIA WAINSCOTT: Before we second it, could I
5 say something?

6 MS. PAMELA S. HYDE: Yeah, let me get the second, then
7 we'll --

8 MS. CYNTHIA WAINSCOTT: Okay.

9 MS. PAMELA S. HYDE: -- do the -- Don? Okay, Don
10 seconds. All right.

11 Conversation, discussion, Cynthia?

12 MS. CYNTHIA WAINSCOTT: I guess the only concern I have
13 is to know that we are not speaking for a group of people.
14 And that is the consumers of mental health services. And I
15 would hope that there would be or has already been maybe
16 perhaps some discussion with -- I assume there's still a
17 Consumers Survivors Subcommittee.

18 MS. A. KATHRYN POWER: Yes. Yes. And the Consumers
19 Survivors Subcommittee actually is meeting on Thursday of
20 this week. And they have really participated in and
21 commented on the entire wellness initiative, which includes
22 smoking cessation. So they've been at the table.

1 MS. CYNTHIA WAINSCOTT: Fabulous. Thank you.

2 MR. ARTURO GONZALES: The other question I had -- and
3 once this gets -- the collaboration takes place and perhaps
4 a change occurs, hopefully the change occurs with FDA. How
5 is this going to be communicated out to family practice
6 physicians, HRSA? It would be a good P.R. for SAMHSA to
7 take the lead on this communication showing integration of
8 medical care and behavioral health as an initiative, you
9 know, as an example.

10 MS. PAMELA S. HYDE: It's a great question. I can tell
11 you that we have time to think about that.

12 [Laughter.]

13 MS. PAMELA S. HYDE: These things take a very, very
14 long time. But we'll ask Mark to think about that and other
15 people think.

16 MR. ARTURO GONZALES: Mark, can you let us know by next
17 week or something?

18 MS. PAMELA S. HYDE: Is there any other discussion
19 about the motion that's on the floor?

20 Larry, about the motion?

21 MR. LARRY LEHMAN: No, about the --

22 MS. PAMELA S. HYDE: All right.

1 MS. HORTENSIA AMARO: I have a question about it. Yes,
2 I'm sorry. So since we haven't seen the letter, I just want
3 to know does the letter make the recommendation about
4 reimbursement for -- no. I'm just concerned about sending
5 -- if there's a recommendation that goes out to
6 practitioners but it's not paid for, it's not covered.

7 MS. PAMELA S. HYDE: Oh, we're far from sending out
8 anything to practitioners. This is just a letter to --

9 MS. HORTENSIA AMARO: No, no, I know.

10 MS. PAMELA S. HYDE: -- FDA saying that CDC and SAMHSA
11 agree with the science behind this need to make a different
12 decision. Then FDA has got to decide if they're going to
13 act on it. I mean, that could take a long, long, long time.

14 MS. HORTENSIA AMARO: Yeah.

15 MS. PAMELA S. HYDE: I think the letter, if I recall --
16 and I'm sorry, I didn't know we were going to have a motion,
17 or we could have had the draft letter here. But usually we
18 don't do those things in draft until they're actually done.
19 But I think it does reference that Medicaid needs that FDA
20 approval in order to consider. So FDA's got to consider
21 this, decide if they want to do it. Then Medicaid would
22 have to decide if they're going to change it. I mean, so

1 it's got a long way to go. But --

2 MS. STEPHANIE LEMELLE: And that was actually one of
3 the initiatives in doing this is that people can't afford
4 nicotine replacement therapy without, you know, a third-
5 party payer. And Medicaid will not cover more than, you
6 know, a time-limited use. And so, that was part of the
7 reason for doing this. So I guess as we move along --

8 FEMALE SPEAKER: Your end goal --

9 MS. STEPHANIE LEMELLE: Right.

10 MS. PAMELA S. HYDE: Larry?

11 MR. LARRY LEHMAN: I changed my mind. It is about the
12 motion.

13 [Laughter.]

14 MR. LARRY LEHMAN: And the point is that one of the
15 essential aspects of recovery is for people to engage fully
16 in life in their community. Increasingly, smoking is being
17 restricted, both in the workplace, restaurants and things
18 like that. Therefore, if you can use something like a patch
19 or gum or whatever of nicotine to control the individual's
20 smoking, the individuals will have more of an opportunity to
21 be able to experience life in the community to the fullest.
22 And that might be an interesting point to add on in terms of

1 marketing this, but also another rationale for the committee
2 to approve.

3 MS. PAMELA S. HYDE: Thanks.

4 Cynthia?

5 MS. CYNTHIA WAINSCOTT: And the thing that is very
6 appealing to me is that it will, if this happens, make more
7 choices available to people. And that's what we should be
8 about, if they are good choices.

9 MS. PAMELA S. HYDE: Absolutely. And let me just say
10 for the record, there's nothing in this, nor would I
11 support, frankly, anything that says we would force people
12 to use nicotine replacement therapy. That is not the point.
13 The point is there's an option here for some people that is
14 not available to them that could be helpful. So for the
15 record.

16 Yeah, Flo?

17 MS. FLO STEIN: Could we use your slides?

18 MS. STEPHANIE LEMELLE: Sure.

19 MS. PAMELA S. HYDE: Yeah, some of the data that's
20 right at the beginning, we should sometimes be a little more
21 careful. I have to go back and look at it. Some of that
22 data is about both people with mental illness and substance

1 abuse disorders in the use of cigarettes. And then the
2 explicit stuff about severe mental illness is very explicit
3 to that group, serious mental illness.

4 All right. Any other comments about the motion? All
5 right. All in favor, say "aye."

6 [A chorus of ayes.]

7 MS. PAMELA S. HYDE: Opposed?

8 [No response.]

9 MS. PAMELA S. HYDE: All right, thanks.

10 Thank you, Stephanie. You not only got us to do
11 something, you got the Council to do something. That's
12 great.

13 All right. Next we have a period of -- or we're going
14 to the SAMHSA's prevention strategy.

15 So, Fran, I'll turn it over to you.

16 MS. FRANCES HARDING: A challenge for me. I used to
17 start off in the career being podium-challenged. And now
18 I'm sitting-challenged. But going with the atmosphere of
19 more of a conversation today, I'm going to sit and see how
20 it goes and see if I've overcome all of my phobias, gone
21 full circle.

22 [Laughter.]

1 MS. FRANCES HARDING: Thank you very much. This is the
2 -- I'm going to speak to you today a little bit about the
3 advances of the strategic initiative one, to remind all of
4 you that's the prevention of substance abuse and mental
5 illness, creating communities where individuals, families,
6 schools, faith-based organizations and workplaces take
7 action to promote emotional health and reduce the likelihood
8 of mental illness, substance abuse, including tobacco and
9 suicide. This initiative will include a focus on the
10 nation's high-risk youth, youth in tribal communities and
11 military families.

12 I always read that because I just have to keep
13 reminding myself that our administrator is expecting us to
14 do all this. So I figure the more I read it, the more I
15 will some day accept it and go forward.

16 [Laughter.]

17 MS. FRANCES HARDING: When she says we reach high, this
18 happens to be one of those initiatives I think we're really
19 reaching high. But we have an excellent team of staff here
20 at SAMHSA. And you'll soon see all of the other federal,
21 state and local partners that are helping us. Again, as a
22 reminder, not to get into a lot of detail, because what I

1 really want to do is to show you the advances we've made so
2 far. We have four goals. They're up there -- for you to
3 read, not as exciting as the opening. But we're basically
4 going to be looking at building emotional health.

5 We're going to prevent underage drinking. And for the
6 first time in a very long time, we're focusing an attention
7 on adult problem drinking, obviously, preventing suicide,
8 looking at that and reducing prescription drug misuse and
9 abuse. Now, what I want you to know, as both you heard
10 yesterday from Westley and Kathryn, we have a multiple -- we
11 have a mix of SAMHSA staff. This is a SAMHSA initiative,
12 not a CSAP initiative. And the first goal is being
13 coordinated by Richard Moore with a partner in CMHS.

14 The second goal is being coordinated by Virginia McKay
15 Smith from CSAP with a partner from CMHS. And the third
16 goal on suicide is being coordinated by Richard McKean, who
17 is in CMHS, partnered with someone from CSAP. And the last
18 goal, which is the prescription drug, is being coordinated
19 by Nick Ruter, who is a CSAT employee and is partnered with
20 someone from CSAT. And that's important for us, especially
21 as you look at what some of our outlying goals, again, the
22 measures that we are being held accountable for are also in

1 the book.

2 And we've actually looked at this a little bit. And
3 for some reason, that's not there. But that's okay. We'll
4 go forward to remind you that we had both population and
5 this SAMHSA-specific. With the 10 minutes I have, I don't
6 want to go in there. If you look at the strategic
7 initiative report, you'll see the four measures that we are
8 being held accountable for.

9 So to update you, you just -- okay. Sorry. Updating
10 the last three months of activity, I started out with the
11 presentation that Stephanie just talked about. So we can go
12 over that one. The one thing I will add to the tobacco
13 initiative is that this was a six-month initiative. And it
14 started in Atlanta with a discussion. And both Dr. Clark
15 and Kathryn's staff have been involved.

16 Sorry, Pete, we didn't involve you much. We will in
17 the future.

18 But the important part about this is a little plug for
19 the exchange, the leadership exchange that Kathryn and I
20 did. I was in the CMHS chair when we were doing the bulk of
21 the work on this particular initiative with nicotine
22 replacement. So I had access to the staff and CMHS. So

1 this is not a foreign thing to them. So when they go to
2 review this with Kathryn in the next couple of weeks, it
3 will certainly -- it won't be something new.

4 In the past three months -- the other items I want to
5 go over with you is that we are focusing on activities
6 around the underage drinking. ICCPUD is the name of the
7 initiative. It's an absolute horrible name, acronym,
8 rather. And I apologize for that. But I didn't create it.

9 It's the Interagency Coordinating Committee on the
10 Prevention of Underage Drinking. We have reestablished
11 ICCPUD. And we had a meeting with Pam. And we are in the
12 process of bringing together all of our partners so that we
13 can begin to focus on the issues of underage drinking across
14 all of the HHS and other federal agencies.

15 In January, we also -- in the underage drinking
16 initiative, we have engaged with our partners in the Office
17 of the Assistant Secretary for Health, Dr. Howard Koh, and
18 with the Office of the National Drug Control Policy, ONDCP.

19 And we are working on an initiative with the new president
20 of Dartmouth College. His name is Dr. Jim Kim. And he is
21 helping us bring together college presidents one more time.
22 This is not the first time that our field has tried to do

1 this, but having a college president lead this initiative to
2 begin to collaborate and look at the issues of binge
3 drinking on the college campus and reduce it.

4 Now, what's interesting to me -- maybe not as my to you
5 -- about this initiative is we initially go after no alcohol
6 use under the age of 21. This particular initiative is
7 starting at a different level. By let's see if we can have
8 some kind of an impact on the most dangerous drinking on
9 college campuses, which is binge drinking. So we're not
10 forgetting the underage drinkers in general. But this one
11 particular initiative is focusing on binge drinking, in
12 particular.

13 Binge drinking is five or more drinks in one particular
14 setting. Dartmouth College is an interesting college to
15 have lead this initiative. If any of us are -- and I think
16 we are, as I look around the table -- old enough to remember
17 Animal House. And that is the college that it portrayed.
18 Enough said.

19 Another great initiative that we're focused on this
20 last three months is that on February 9th, the second
21 meeting of the National Alliance -- Action Alliance for
22 Suicide Prevention was held in Crystal City, Virginia. And

1 it was convened by the two co-chairs of that initiative,
2 Senator Gordon Smith and the Secretary of the Army, John
3 McHugh. This alliance brings together -- has 10 task
4 forces. And in their initial meeting, they focused on
5 national strategy for suicide prevention, research, data and
6 surveillance, American Indian and Alaska Native issues,
7 LGBTU, survivors of suicide attempts, clinical care, faith
8 communities, public awareness, clinical work groups.

9 It was a very rich and interesting, in-depth debate
10 that has really launched an initiative that this is under --
11 it's important for you to see the cross-walk with
12 prevention. This is an initiative that Kathryn Power
13 actually leads with her staff. But it's part of this
14 prevention initiative for SAMHSA.

15 We also, in January, hosted a -- SAMHSA hosted a
16 meeting of its grantees funded under the Garrett Lee Smith
17 campus suicide prevention grant. I'll discuss this in a
18 second in more depth as well, especially I asked for some
19 more detailed information because of our conversations
20 yesterday around the college and university campuses. So I
21 wanted to get into a little more depth of what we're doing
22 there.

1 Let's see. Where else? Sorry, my slides are not
2 synched with my notes.

3 The Behavioral Health Coordinating Committee on
4 Pharmaceutical, which we commonly refer to this as the
5 Behavioral Health Coordinating Committee on Prescription
6 Drugs. It depends who you are and how you describe this.
7 The subcommittee has drafted its mission statement and four
8 action steps.

9 I should tell you to remind you, the Behavioral Health
10 Coordinating Committee is the committee under Health and
11 Human Services that is co-chaired by Pam and by the
12 Assistant Secretary for Health, Dr. Howard Koh. And I have
13 the honor of working with the subcommittee that focuses on
14 prescription drug misuse.

15 We have recently gotten together our plan of -- and
16 we're working with the -- we're developing a plan for the
17 Behavioral Health Coordinating Committee. We talk in
18 acronyms, so I'm doing a little language change in my head.
19 And this is all about acronyms, which I'm about to tell you.

20 And we're also working with the Office of National Drug
21 Control Policy because we want to make sure that the plan
22 for the interagency Coordinating Committee on Prescription

1 Drug Misuse is consistent and supportive of the Office of
2 National Drug Control Policy's chapter on prescription drug
3 misuse. That seemed to take a long time to get out.

4 The subcommittee members -- this committee is led by
5 NIDA, National Institute on Drug Abuse, and the FDA, the
6 Food and Drug Administration. Our significant partners in
7 advances of what we are doing in this subcommittee -- our
8 major partners are, not only NIDA and the FDA, but CDC. And
9 I would be remiss if I didn't include them in this.

10 Skipping along to everything that we're doing, one of
11 the other interesting things that is not up here is that we
12 are also working with the DEA, the Department of Drug
13 Enforcement Administration, on their prescription drug take-
14 back program. Now, we've had take-back program on September
15 25 in 2010. More than 3,000 sites in the nation
16 participated in that take-back program. And we had 121 tons
17 of pills confiscated and destroyed appropriately because of
18 that success. And this is in combination with many states
19 that have their own take-back programs. So I think that's
20 even more of an impressive number.

21 They have scheduled a second take-back program. And
22 it's very soon. It is almost soon, in a sense, April starts

1 Friday. It's scheduled for April 30, 2011. And more
2 information, if you want to look into where the sites are
3 going to be held and all the details of that, can be found
4 on the Web, www.dea.gov, an easy one to remember.

5 I told you I'd tell you a little bit about the ICCPUD.
6 Basically, I will skip over the facts that most of us know.
7 The reason why SAMHSA is spending so much time on underage
8 drinking is we want to make this a national concern. We
9 want to raise it up to the nation because we still have
10 5,000 youth under the age of 21 that die each year. And we
11 just can't ignore that any longer.

12 On New Year's Day in 2009, there were an estimated of
13 almost 2,000 emergency department visits involving underage
14 drinking. That's a lot. We know that's a high time when
15 drinking is sometimes indulgent. But to have that many
16 underage drinkers, that's any drinkers under the age of 21,
17 that's -- and also, this is an increase of 250 percent over
18 average part of the year.

19 We also have recorded with all the good work that we're
20 doing -- and we are making great strides in the eighth, the
21 tenth and the twelfth graders in binge drinking across the
22 country. We are still tracking 10 million drinkers,

1 underage drinkers. So this is something that we are going
2 to spend a lot of our time on.

3 Garrett Lee Smith -- Garrett Lee Smith program focusing
4 on campus suicide is becoming one of the most requested
5 piece of information that I receive in the office on almost
6 regular basis in partnership, again, with Kathryn's staff,
7 who are focusing on this problem. More than 4,000 youth and
8 young adults die each year by suicide. Because I am on the
9 Center of Substance Abuse Prevention, I always get the
10 question, "Why are we worried or focusing on suicide." And
11 when you see the numbers, I know. Someone is shaking their
12 head. And it's because our field is just learning.

13 And when they see the statistics and they know what we
14 know here in the room, they are listening, and they want to
15 do more. So we have been working with CMHS. And we are
16 combining our efforts with alcohol and suicide together.
17 Alcohol is suspected in two-thirds of all cases of college
18 suicides. I'm sure that's not a surprise to us in this
19 room.

20 The Garrett Lee Smith Memorial Act named in the memory
21 of former Senator Gordon Smith's son, who died by suicide
22 while at college. And it authorizes funding that enables

1 this initiative to continue. In 2009, SAMHSA awarded grants
2 to 22 new colleges and universities. That brings up our
3 total in SAMHSA of awarding 93 university campuses with this
4 program. The grant includes training students on campus
5 personnel, creating a network and infrastructure, providing
6 educational seminars, operating local hotlines and promoting
7 the National Suicide Prevention Lifeline, 800-273-talk, and
8 providing materials upon will.

9 When you were talking about, Donald, part of this
10 program, this is something I was thinking of when you were
11 speaking about what you were doing in higher education.

12 More than 1.7 million students and grantees and
13 campuses were exposed to suicide prevention and mental
14 health awareness campaigns. This program, for the little
15 bit of money that it has, is really have far reach into our
16 colleges. And that's it.

17 MS. PAMELA S. HYDE: Okay, Fran, thanks.

18 Just a couple of things before I open it. I wanted to
19 just remind you that part of the 5 season why we're focusing
20 -- I said this yesterday in a general sense. But I want to
21 say it explicitly here. Part of the reason why we're
22 focusing so much on youth or people under age 21, youth and

1 young adults in our entire prevention effort is because we
2 think we can have as big an impact on adult substance abuse
3 and mental health issues by focusing on young people as if
4 we tried to spread our resources in a way that we just don't
5 have enough resources. So we are focusing there.

6 We know in underage drinking, for example, that for
7 young people who start drinking under age 21, they're more
8 likely to have an adult dependence or adult issue. So
9 that's why the focus is so much there, not to mention which
10 there's also congressional direction and other requirements.
11 But we're doing it because it's the right thing to do.

12 And then on the suicide issue -- and, again, Fran or
13 Kathryn or Wes, or any of you can join in on any of this
14 data. But I'm always struck by the fact that there are more
15 people who die by suicide than from HIV AIDS and more people
16 who die by suicide than by homicide. And if you think about
17 where our country's concern is -- and I'm not in any way,
18 shape or form trying to reduce the concern about HIV AIDS or
19 homicide, but we need to get people to be just as concerned
20 about a source of death that's higher than those even.

21 So any comments from the other three -- or the other
22 center folks? Because I know this one is definitely one

1 that crosses everything. Or even, Pete? See, I did it,
2 too. The other three centers. There's four altogether.

3 MR. PETER DELANY: I keep thinking of myself part of
4 the folks.

5 MS. PAMELA S. HYDE: We'll get used to it.

6 All right, Kathryn, you want to say anything?

7 MS. A. KATHRYN POWER: I just wanted to add that the
8 statistics continue to be startling. And for the last year
9 that we have actual data, 34,000 people committed suicide or
10 completed suicide. And one of the interesting NISTA reports
11 that Pete was able to do was that we, under the NISTA in
12 2009, I think in '09, we asked the question about how many
13 people contemplated suicide. And, you know, over 8 million
14 people responded that they contemplated suicide. Now,
15 there's less and less numbers of people that actually make a
16 plan, that actually attempt.

17 MS. PAMELA S. HYDE: About a million, right?

18 MS. A. KATHRYN POWER: That's right. That's right.

19 MS. PAMELA S. HYDE: That attempt?

20 MS. A. KATHRYN POWER: And so, people contemplate it.
21 They make a plan. They attempt it. And they may, in fact,
22 then complete it. But it's a very serious public health

1 issue. And, frankly, one of the difficulties -- and I think
2 one of the most amazing things about the fact that we're
3 talking about prevention suicide in a strategic initiatives
4 is that we have to get people to talk about it.

5 And it's very difficult to get people to talk about
6 suicide. And raising an awareness about it in different
7 cultures, I think it's a cultural issue. And we've talked
8 about that across in various groups. But just being able to
9 frame it and talk about it in a way that is accepting and
10 building awareness, I think, is one of our goals.

11 MS. PAMELA S. HYDE: The other issue, before Wes speaks
12 in here, is on the adult problem drinking issue. I told you
13 earlier I wanted to tell you something when Arturo raised
14 the issue about what do we want you to do. Just in general,
15 I want to raise the issue that there's going to be a
16 nutrition-related reg. come out soon in the federal register
17 that has to do with restaurants identifying the calorie
18 count in certain foods.

19 And my understanding is that the calorie count for
20 alcohol is going to be -- alcoholic drinks is going to be
21 left for public comment, not because the department doesn't
22 want to do anything about it, but because the issue of

1 what's a drink and how much is a drink and the comparisons
2 about how one bartender puts a drink together compared to
3 another one and all that is a little difficult. So what
4 they're asking for is public comment. And I think we want
5 all of the folks who care about substance abuse in our
6 communities to be prepared to make some comment about at
7 least the need to have alcohol content -- I mean, calorie
8 content and count connected to those drinks is really
9 important. Because there definitely is a growing interest
10 on the part of the public at paying attention to how much
11 calories they take in. So to the extent that we can get
12 them to think about it that way, that might be helpful.

13 So, Wes, did you want to add anything?

14 MR. WESTLEY CLARK: Yes. It's clear that with the
15 issue of suicide, we need better data and better
16 classification schemes. And we need to be able to
17 differentiate the various populations. I think Kathryn's
18 point about the cultural context is a very important one.
19 And since this whole discussion, in many instances, for
20 certain populations, is terribly delicate, we need to be
21 able to figure out how we can assist the data collection
22 efforts so that we can get a proper characterization of what

1 it is that we mean.

2 In our SAYS data, we ask about suicidal impulses. And
3 while people are under the influence, it tends to be higher
4 than when they're not under the influence. So Fran's point
5 about substance-related suicidal ideation is an important
6 one because, indeed, it avoids -- when you're adding
7 substances, whether it's alcohol or other drugs, to the
8 ideation, it contaminates the more, quote, "purist" view of
9 what suicide means from a symbolic point of view.

10 So what we do want to establish is that those suicides
11 that are, quote, "avoidable," we want to certainly avoid
12 them so that it's not a rational decision on the part of the
13 individuals so affected. So taking alcohol and drugs --
14 calculus assist us tremendously in dealing with some of the
15 cultural issues associated with the, quote, "thinking" about
16 suicide and that that's a very important thing. So this is
17 something that we clearly need to continue to work very
18 aggressively on.

19 MS. PAMELA S. HYDE: Fran, you jumping in here? And
20 then I'll open it up.

21 MS. FRANCES HARDING: I just wanted to say one thing,
22 that having the suicide underneath or within the strategic

1 initiative has given people, everyone, the opportunity to
2 talk about it. And they have been working with it. But
3 they haven't felt, as a general feel, that it was okay for
4 them to talk about it. And it also then helps to begin to
5 disintegrate the competition between which is worse. Should
6 I be focusing on underage drinking, or should I be focusing
7 on suicide because suicide's more important today?

8 Underage drinking is more important tomorrow. Adult
9 drinking and then pharmaceutical misuse is another. And
10 it's just helping to blend in the prevention world, which I
11 think is really the world of the community giving permission
12 that all of this does go together. So I just wanted to give
13 a plug for the initiative.

14 MS. PAMELA S. HYDE: Thanks.

15 And as we go down -- and hopefully, Lark will jump in
16 on what I'm about to say. As we start to drill down into
17 these initiatives, you can see where the overlaps are
18 between either other initiatives or certainly in the
19 disparities area. So we can't talk about suicide with
20 starting to unravel -- for example, we talked about earlier
21 Latina youth or LGBT youth or military families or whatever
22 and the differences among those attempters and completers.

1 So, Lark, did you want to add to that?

2 MS. LARK HUANG: Yeah, I was just going to add a little
3 bit to that. I think around the suicide piece, you know, as
4 we think about the campus suicide grants and as we build
5 these networks of the HPCU or the tribal college and
6 universities, how well they are competitive to go for those
7 tribal -- those campus suicide prevention grants, given the
8 high rates among those populations. I think also what's
9 neat about, I think, this initiative is that I think we have
10 good data around these. And I think we can break out the
11 data by different race and ethnic groups, but also within
12 that.

13 So, for example, if you look at -- and when college
14 students drink to binge, you know, their purpose is to binge
15 drink. So that's a college course, you know. But I --

16 MS. PAMELA S. HYDE: Said as a mother of a college
17 student.

18 MS. LARK HUANG: I know. One more. Yeah.

19 But I think the other thing is looking in our data --
20 and I think NISTA is one of the few federal data sets that
21 really disaggregates within groups. So if you look, for
22 example, at the Asian drinking data, as a group, it's low.

1 But if you disaggregate it -- and we disaggregate it by
2 Native Hawaiian Pacific Islanders -- those youths are the
3 highest binge drinkers. Okay?

4 If you look at African-American youth, they're low
5 until they get above 18. So I think it's important for us
6 to say what are the protective factors when they're still
7 below 18 that then they accelerate. You know? So I think
8 we have a lot of good data here that can really help us be
9 very strategic about how we sort of deploy resources in this
10 effort.

11 MS. PAMELA S. HYDE: We're also figuring out some of
12 the connections between the 18 to 25-year-olds who go to
13 college and the 18 to 25-year-olds who go to the military
14 and the 18 to 25-year-olds who do neither. And so, there's
15 some connection between the 18 to 25-year-olds, regardless
16 of where they go. So to the extent the military is
17 experiencing more issues in that age group, too, that's also
18 significant.

19 MS. LARK HUANG: And just one other thing. I mean, I
20 think to really highlight that one of our suicide action
21 alliance task force is on LGBT youth and all of the bullying
22 issues that have been associated with that recently. So

1 that's great.

2 MS. PAMELA S. HYDE: Okay.

3 I think I have Arturo next then Don.

4 MR. ARTURO GONZALES: I wanted to -- I've seen the work
5 on the campus suicide prevention grants.

6 And you're absolutely right, Fran. They're really
7 reaching out and doing some excellent work with regard to
8 the college youth. In New Mexico, Senator Mary Jane Garcia
9 sponsored two bills on bullying, the reasons for bullying
10 and how schools are going to address bullying and that they
11 had to come up with action plans on how the school districts
12 were going to deal with students who were bullies and also
13 help students who were being bullied.

14 The question I have is we're talking about underage
15 drinking. What about -- maybe there's no way to -- this is
16 going to sound funny, but underage suicide. What I mean by
17 that is what about the minority youth that a large number
18 don't end up going to college? They don't go to college.
19 They may not go into the military. You know, they're just
20 kind of staying at home or whatever, working. They may drop
21 out. What about efforts to deal with the high school
22 student, putting resources there or even earlier than that?

1 Because there's a lot of high school kids and even
2 elementary, junior high kids that are really dealing with
3 the stresses and thinking of contemplating suicide.
4 Anything on that?

5 MS. FRANCES HARDING: One of the reasons why this
6 initiative, this particular goal, is led by Richard McKean
7 is because he is the director of our suicide program in
8 CMHS. So I'm going to punt this one over to Kathryn, who
9 knows a lot more in-depth.

10 MS. A. KATHRYN POWER: I think one of the things we try
11 to do, Arturo, is make the connection between what is
12 available about suicide prevention material and reach lower
13 and lower into the age groups in a number of ways. So, for
14 example, we're trying to get the suicide prevention material
15 connected with the safe schools, healthy students program.
16 We're trying to get it connected to Fran's work with the
17 drug-free community folks because they're the ones in
18 community coalitions who have to reach into the high
19 schools, who have the reach into the youth groups, who have
20 the reach into that age group in sectors across the
21 communities. So the more we can get that advanced
22 materials, programs, you know -- what the college campuses

1 do is a gatekeeper program that certainly has applicability
2 in high schools, too. And so, the more we can get the
3 prevention leadership and the prevention community
4 coalitions to pay attention to this, the wider and deeper
5 the reach can be about what is known about the prevention
6 science for suicide.

7 MR. ARTURO GONZALES: I'm wondering if the
8 collaboration with HRSA, for example, that may fund -- you
9 know, it funds the community health centers and also school-
10 based health centers -- wouldn't be a good place to exert
11 some of these efforts.

12 MS. A. KATHRYN POWER: Absolutely. I think that's a
13 tremendous suggestion. And we are doing that in some ways,
14 but we can do more of that. In other words, the health
15 center becomes a very key part in just in terms of
16 messaging, you know, picking up the pamphlet, picking up the
17 cards, doing those kinds of things for the health center.
18 And I think that's an excellent suggestion.

19 MS. PAMELA S. HYDE: Okay, I have Don and then
20 Hortensia and Stephanie. And then I think we're going to
21 try to move to public comments.

22 So, Don?

1 MR. DONALD ROSEN: Yeah, I have a brief comment and an
2 offer. And that is that the ACGME, the Accreditation
3 Council on Graduate Medical Education, is currently
4 reviewing and changing their guidelines for general
5 psychiatry and for all of sub-specialties. And I'm the
6 incoming vice-chair of that committee. And I am the chair
7 of the Addictions Rewrite Committee. And we have solicited
8 public input from a number of groups, but not from this
9 group. And I can forward you what we've got so far and get
10 your input as we put the final touches on what we're going
11 to do. And as we move toward the general guidelines, I'll
12 include you in that, too.

13 MS. PAMELA S. HYDE: That'd be great, Don, because
14 there's actually a task force of action alliance about
15 clinical standards. So we need to get you connected to
16 that.

17 MR. DONALD ROSEN: I'd be delighted.

18 MS. PAMELA S. HYDE: That'd be great. We need help
19 there. And HRSA's one of the co-chairs of that.

20 So, Kathryn, can you make that connection?

21 MR. DONALD ROSEN: Yeah, that'd be great. Thank you.

22 MS. PAMELA S. HYDE: All right.

1 Hortensia?

2 MS. HORTENSIA AMARO: So I'm really happy to hear about
3 these activities because I've done some work on -- and we've
4 done some publishing and some interventions on underage
5 drinking and alcohol, heavy drinking and binge drinking,
6 college students.

7 There is a study that's being done by one of my
8 doctoral students for her dissertation, which is a national
9 representative survey of four-year colleges and universities
10 to look at the extent to which they've really implemented
11 the FERPA requirements and for parental reporting and also
12 looking at the factors, how is it -- what are the many ways
13 in which colleges and universities are actually implementing
14 this and what are the factors that influence that.

15 And so, I think that probably it'll be, you know, ready
16 in about six or eight months. So if this group is still
17 meeting the college president, I assume it's going to be a
18 group that's going to work together, it might be a good
19 resource because the other studies that have been done in
20 that area have had a lot -- a different -- and different
21 types of limitations in terms of the sampling hasn't really
22 been representative, et cetera.

1 The other one I wanted to say is the area of suicides,
2 when we did -- for three years, we did representative
3 sampling of college students, of our students at
4 Northeastern University with the NIAAA grant that we had on
5 substance abuse. And one of the things that we found was,
6 of course, no surprise, the high rates of problem drinking
7 and then suicides among GLBT students. And we had some
8 questions in our survey about how they felt about the school
9 environment and being harassed. And it was, you know, a
10 relationship there in terms of those students at risk.

11 And one of the things that we noticed was that the
12 efforts to address issues of suicide and college drinking,
13 et cetera, really were not reaching the GLBT community. And
14 I met with the student representatives, the LGBT groups on
15 campus. And they were requesting like a safe place, you
16 know, a student center. A lot of them didn't -- felt like
17 they couldn't really -- didn't feel comfortable going to the
18 health center. And I guess that would differ, you know,
19 across campuses, et cetera.

20 But I hope that in that effort, there is -- and in
21 those proposals, as you look at them, that you think about
22 -- this is the cross-walking, again -- issue between Lark's

1 initiative and this one of that in addition to reaching the
2 general population on campus, that there are certain groups
3 that may need kind of a different space to feel safer.

4 And the last issue was about adult drinking. And I'm
5 wondering how the issue of the high rates of heavy drinking
6 among Latino immigrant men, whether there are initiatives to
7 address that as part of your efforts.

8 MS. FRANCES HARDING: To the last, not that I know
9 specifically. Lark may know more. But Steve Wing is our
10 contact here within.

11 MS. HORTENSIA AMARO: Yeah.

12 MS. FRANCES HARDING: And you know Steve, that's
13 actually leading the adult drinking. But I can -- I'll
14 bring that back.

15 But a couple of things I do want to talk to you about.
16 One is, for your doctoral student, she really, if she hasn't
17 already, look into the Higher Education Center. They have a
18 lot of what you're saying she's looking for. They have that
19 all documented. They know what colleges are doing, what --
20 in substance abuse, particularly around alcohol and underage
21 drinking both, binge drinking and just underage drinking in
22 general.

1 MS. HORTENSIA AMARO: Okay.

2 MS. FRANCES HARDING: That's sponsored by the
3 Department of Education. It's very easy when she goes on
4 the Web to get it.

5 MS. HORTENSIA AMARO: Okay.

6 MS. FRANCES HARDING: The second thing, the National
7 Institute of Alcoholism and Alcohol Abuse is, I guess,
8 reenergizing their task force on college presidents. The
9 college initiative that Dr. Koh was bringing together is now
10 Dr. Kim from Dartmouth has now agreed to co-chair NIAAA's
11 task force on college presidents.

12 MS. HORTENSIA AMARO: Great.

13 MS. FRANCES HARDING: Which I think will bring a new
14 flame to that. And that's another area she may want to look
15 at.

16 MS. HORTENSIA AMARO: That's great.

17 MS. FRANCES HARDING: And the LGBT and college and
18 drinking, this is one of those kind of interesting things
19 where as the bullying issue with LGBT youth and the drinking
20 that goes along with it has started to spark in the
21 elementary and middle school area.

22 MS. HORTENSIA AMARO: Yeah.

1 MS. FRANCES HARDING: It is now then sparking an
2 awareness at the college level that I have not seen before.
3 So this is one of those -- usually it's college trying to
4 find a reason to go down in to the high schools because
5 those are the feeders of all the underage drinkers coming on
6 campus. This time it's in reverse. So I don't think it
7 matters who's first, but it's just another interesting area
8 where that awareness really is coming from those high school
9 students asking for these things, those safe places. I have
10 also heard some campuses asking for dormitories that are
11 carved out.

12 We have dormitories for people in recovery. We have
13 dormitories for quiet and a whole bunch of other things.
14 This is another area that's being explored. We just
15 couldn't put all that in 10 minutes.

16 MS. PAMELA S. HYDE: Okay. We are getting close to
17 needing to open it up for the public.

18 So, Stephanie and Cynthia, and then we're going to do
19 that.

20 MS. STEPHANIE LEMELLE: Just this is to Lark, that
21 there is some interesting data looking at binge drinking and
22 alcoholism between residential colleges and universities and

1 commuter colleges and universities, which is really
2 interesting the way the data sorts out as a sub-population
3 to look at. I had a question about the DEA take-back
4 program. Is that for all prescription medications?

5 MS. FRANCES HARDING: Yes.

6 MS. STEPHANIE LEMELLE: Okay.

7 MS. FRANCES HARDING: Yes.

8 MS. STEPHANIE LEMELLE: That's really -- I mean, I
9 hadn't heard about that, so I'm really interested in hearing
10 more about it.

11 MS. FRANCES HARDING: Yeah, it's for all prescription
12 drugs. And we can give you some more information on it.
13 And it is one of their -- it's becoming one of their most
14 well-known programs in the DEA, which I'm not sure if they
15 like or not like. It's not really a DEA prime thing. But
16 they have, along with that, a medicine cabinet campaign to
17 help parents and people who have guardian over children to
18 understand that they're getting it in their medicine
19 cabinet.

20 Just as a quick analogy in underage drinking, we used
21 to use the refrigerator door as our symbol because that's
22 where the kids are getting the beer mostly for underage

1 drinking. And now we're using the medicine cabinet for
2 drugs. So it's working really well for them.

3 MS. PAMELA S. HYDE: All the staff who said I'll get
4 back to you about that, could you make sure whatever it is
5 you're providing gets to Toian so we can get it to
6 everybody?

7 Okay.

8 What else, Stephanie?

9 MS. STEPHANIE LEMELLE: Well, just that I'm really
10 happy that you are doing this carve-out on the prescription
11 drug abuse issue because I really do think the approaches to
12 dealing with it are a little bit different than the other
13 substance abuse and alcohol issues.

14 The other issue I wanted to just put out there about
15 suicide is this sort of, I guess, rising view or tendency of
16 African-American young men to do what's called suicide by
17 police, where they are exposing themselves in a very
18 vulnerable way to be shot by the police, which is something
19 that we haven't really talked about, but again, a sub-group
20 that might be worth looking into.

21 MS. PAMELA S. HYDE: Cynthia?

22 MS. STEPHANIE LEMELLE: Yeah, suicide by cop.

1 MS. CYNTHIA WAINSCOTT: I'll be quick. I would like to
2 thank Kathryn Power for being so tenacious and courageous
3 about getting the suicide network going. I was up close and
4 personal as that was happening. And I really appreciate
5 what she did.

6 Suicide is very personal for me. As a child, I saw my
7 mother attempt suicide. That's life-changing. I tell you
8 that because you may not believe it with what I'm going to
9 say next. I see the strategic plan for the prevention
10 activities movement into putting money on the table for the
11 states so that they will begin doing prevention work as one
12 of the most important and far-reaching things we've talked
13 about doing. But if all we get back from that is more
14 suicide prevention activities, we will have missed a huge
15 opportunity.

16 So I hope some real serious thinking will be done about
17 how to convince the people who will make decisions about
18 whether to get that money and then what to do with it will
19 understand universal, selective preventions in addition to
20 the prevention of terrible life outcomes. It won't happen
21 unless there's a really good plan for it. And I hope we do
22 it. I hope that a year and-a-half or two years from now, a

1 panel will come to this group and will say, "We want to tell
2 you what they're doing in the states with that prevention
3 money."

4 And they will be finding mothers who have post-partum
5 depression. It will be doing Rick Price's jobs program. It
6 will be the things that we know that work but which we are
7 not doing now and which are often not even believed.

8 MS. PAMELA S. HYDE: Thanks. Actually, you raise a
9 good question because I think probably we should bring back
10 to the table some conversation and get some advice from you
11 about those prevention grants, even before we know whether
12 we'll get them or not. We need to think about that a little
13 bit. So thanks for that.

14 I've got Terry raising his hand now, so this really is
15 the last comment because we need to get to public comment.

16 MR. TERRY CROSS: Just quickly, I want to make sure
17 that we keep in this discussion the protective factors of
18 culture. I think it's been referenced as being a problem to
19 help understand the problem. But a recent study in British
20 Columbia, 90 percent of the suicides among Native youth
21 could be accounted for in 10 percent of the communities.
22 And the only factor across those communities was the

1 breakdown in the cultural society.

2 MS. PAMELA S. HYDE: Very good point, Terry. Thanks.

3 Okay. I don't think we have anybody on the phone that
4 has registered for a public comment, but we're going to let
5 anybody in the audience here have an opportunity to make a
6 comment. So if anybody wants to do that, would you please
7 come to the microphone and say who you are? This microphone
8 up here. Say who you are.

9 Yeah, come on up. Yeah, we need your name and who you
10 represent, if you do.

11 DR. STEVE ESTER: My name is Dr. Steve Ester. And I
12 used to work for the New York State Office of Mental Health
13 in New York City, was the Director of Adult Services under
14 Commissioner Serles. And I retired. I've kind of been
15 involved with SAMHSA.

16 And basically, in my career, I worked heavily with
17 adult population, child and youth. And I guess as I've
18 gotten older, I've become very sensitive to the issue of
19 older adults. My wife worked for Robert Butler, who started
20 the National Institute of Aging and the International
21 Longevity Center, which originated out of Mount Sinai. But
22 the thing that struck me in the discussion here was the

1 parallel impact of some of the issues that you talk about
2 with children, youth and adults on older adults.

3 For example, trauma is prevalent amongst elder abuse.
4 It's an overlooked factor. You cannot get funding for it.
5 It's very difficult to develop programming for it, although
6 it's prevalent.

7 We recently did an initiative in Manhattan for older
8 individuals who were facing eviction. And they were
9 predominantly women, fixed income whose husbands had died.
10 They then were facing eviction by the marshals, who then
11 pleaded with the Manhattan Civil Court judge, "Please, don't
12 have us do this."

13 So they asked us to write a grant. I set up an act
14 team, which the Manhattan Civil Court actually gave us space
15 to run out of their courtroom. Unfortunately, the National
16 Institute of Aging, I think, ran out of funding and it was
17 never funded. So you had the issue of homelessness amongst
18 the elderly. You have the issue of trauma.

19 Another issue of depression, I believe, Asian elderly
20 have the high suicide rate, as do Latina adolescents. So
21 you have the issue of suicide. You have the issue of
22 homelessness. You have the issue of trauma.

1 And the last piece that I felt has never really been
2 addressed -- and I've done a lot of SAMHSA reviews in terms
3 of substance abuse, block grants, CMHS -- where you get
4 minorities and dealing with the issue of substance abuse and
5 HIV AIDS. But I believe HIV AIDS amongst the elderly,
6 partly because it's a generational issue, is a rising
7 factor, I would assume, down in Florida -- and I'm not
8 making that as a joke.

9 And the other issue in terms of substance abuse amongst
10 the elderly is misuse of medication for pain, sleep,
11 depression and also in terms of misuse of over-counter
12 medication. And I haven't seen any initiative designed to
13 deal with that. So what I'm really just saying -- in the
14 two days I've been here, I really haven't heard much to be
15 said about older adults. And I don't know if it's an
16 omission or -- I do believe the population is growing. They
17 present problems that cross over all developmental ages.
18 And I wonder what the committee feels about this.

19 MS. PAMELA S. HYDE: Thanks for your comments. There
20 are, in many of our programs, no age differences. So many
21 of our programs deal with all ages. There are a couple of
22 initiatives that we're doing with the Administration on

1 Aging, which didn't come up yesterday. But we are trying to
2 work with them on prescription drug abuse information and on
3 suicide prevention, warning signs and other kinds of things.

4 We have relatively little money that is targeted to
5 older adults. So what we're trying to do here is look at
6 all the other work that the other agencies are doing and
7 seeing where we can have some impact. We do have a small
8 program there, but not a lot.

9 So it doesn't mean that we don't care about those
10 groups. But we are having to, unfortunately, make tough
11 decisions about where we have resources and where we don't
12 and where we can make the most impact with the resources we
13 have. That is not to say we could laundry list a jillion
14 other things we care about and wish we could do more about.
15 And unfortunately, some of that is limited.

16 But having said that, I don't know if Wes or Kathryn
17 want to jump in here.

18 MR. WESTLEY CLARK: We have actually worked with the
19 Food and Drug Administration on media campaigns to educate
20 consumers about the issue that you're raising. Yvette
21 Torres, who is on working in the CSAT arena has worked with
22 the FDA on that. And you're right about the issue of

1 multiple medications. As Pam pointed out, since we don't
2 have endless resources, we've been working with our partners
3 to address some of these themes.

4 And clearly, with health reform, this is going to be an
5 increasing issue. And with HIT, we'll be able to identify
6 many issues associated with medication. One of the themes
7 in HIT is making sure that electronic health records track
8 prescriptions, not just for the purpose of abuse, but for
9 the purpose of -- some adverse reactions, et cetera. So
10 that figures into the calculus.

11 MS. A. KATHRYN POWER: Our very small program for older
12 Americans has traditionally focused on grantees that are
13 actually the forerunners of primary care and behavioral
14 health integration, which is where a lot of older
15 individuals go for their behavioral health services they get
16 through a primary care practitioner.

17 So what we've tried to do is learn from those grantees
18 over the years. And now, with our primary care behavioral
19 health larger demonstration program, we're seeing
20 opportunities to take what we've learned about what works
21 effectively in messaging around all those issues with older
22 Americans and trying to bring that into work with the

1 primary care behavioral health integration demonstration
2 project. And that, in and of itself, I think, will help
3 inform some of the reach-out that we're going to do with the
4 Administration on Aging in getting some of the evidence-
5 based and content practices that we're familiar with, in
6 terms of mental health and substance abuse, into a much
7 wider dissemination and dispersion pool.

8 So that we're trying to, I think, exponentially move
9 what we've learned about how to interact and engage older
10 Americans on those issues because they traditionally are not
11 going to mental health centers or to substance abuse
12 agencies, but are coming in through the primary care
13 initiatives. So I think there is hope for that. And I'm
14 very appreciative that we'll have that opportunity through a
15 number of the strategic initiative approaches.

16 MS. PAMELA S. HYDE: This is one of those areas where
17 you cannot look just at our budget or even just at our words
18 and see what's happening because there is so much that we
19 can and do influence in other places. The department as a
20 whole has a significant amount of effort going on around
21 older adults, whether it's in Medicare or Medicaid or other
22 areas. And to the extent that we are trying to impact those

1 systems -- and, for example, one of the interactions that
2 has come up lately between Wes and Fran and the
3 Pharmaceutical Committee and ONC is how electronic health
4 records can become the next wave of assistance for
5 prescription drug monitoring and drug interactions.

6 And if we can make that happen, that will have a pretty
7 profound impact for seniors in trying to make sure that they
8 don't inadvertently misuse prescription drugs. So there's
9 all kinds of work going on in areas like that that won't
10 necessarily show up explicitly in a strategic initiative or
11 explicitly in a funding line in SAMHSA. So in these cases,
12 we do the best we can with the limited resources we have and
13 really try to influence the field and I think are doing a
14 fairly good job at that with not much to use to do it.

15 All right. I saw another hand out here.

16 Yeah, Yolanda?

17 MS. YOLANDA BRISCOE: Hi. My name's Yolanda Briscoe.
18 I'm representing myself and the Santa Fe Recovery Center. I
19 wanted to say thank you to SAMHSA for continuing to
20 encourage and support collaboration amongst communities and
21 different organizations.

22 So I jotted down, in listening to the disparities --

1 and I jotted down real quickly six quick things that we're
2 doing in our agency and on a personal level to address
3 disparities that don't cost a lot of money. One of the
4 things that we did is we partnered with the Santa Fe
5 Mountain Center to come and train our staff on LGBTQI
6 consumers and particularly trans-gendered individuals. And
7 in response to that, then we went and trained on medical
8 management, our nursing and medical staff went and trained
9 their staff on medical management.

10 And we partnered with Solace, which was formally known
11 as the Santa Fe Rape Crisis and Trauma Center. We partnered
12 with them. They're the experts, and they do evidence-based
13 practices and best practices in dealing with men and women
14 who are experiencing trauma. So an individual comes to
15 residential treatment with us. And that's not to say that
16 we don't deal with trauma at our center, but we -- and
17 provide transportation to clients to go and receive trauma
18 services with them. And the good thing about that is then
19 they have the continuity of care after graduating from our
20 residential program. Then they continue on with Solace,
21 even though they may not continue with outpatient services
22 with our facility.

1 Next thing we did is we support and encourage and
2 provide tuition assistance and encourage individuals. We
3 have three women in the six years that have so far graduated
4 with a master's in business, a Ph.D. and a master's in
5 social work by providing supports in the workplace,
6 adjusting schedules, allowing women to bring their children
7 to work sometimes and also providing the tuition assistance
8 support and scheduling shifting. Depending on when classes
9 are being held, we shift work schedules.

10 Some of our neighboring pueblos, we have contracts
11 where we offer services for half the price of what we ask of
12 the general population. And we do this so that we can more
13 accurately reflect what New Mexico looks like in our
14 treatment center. In that partnership, I have also a
15 personal contract with one of the largest pueblos in New
16 Mexico. And in talking to the director, one of the -- some
17 of the challenges that they face in engaging clients is the
18 confidentiality. Another is shame around actually going to
19 the behavioral health center.

20 And so, what we have done is we are starting a pilot
21 program where clients will come to our facility for day
22 treatment. They're not going to stay there all night. And

1 they will become engaged in our wellbriety model that we use
2 for the entire population so that they're not, "Oh, these
3 are the Native Americans, and they're going to do
4 wellbriety, and everybody else is going to do 12-Step." So
5 everybody participates in the wellbriety model.

6 And then they get engaged in 12-Step programs and then
7 transition back into the pueblos, where perhaps they may
8 feel more comfortable than attending groups there. So in
9 order to meet the client where they are, we also see in the
10 pueblos adolescents who -- somebody said this yesterday,
11 that adolescents get made fun of when they go to the
12 behavioral health program. And so, what I do with the --
13 and this is what you learn from the client.

14 A client told me, "I'm embarrassed to come here because
15 my friends will make fun of me. They already know that I
16 cut and I attempted suicide. And so, I said, "Well, you
17 know, I'm a psychologist, but really, I consider myself an
18 educator. So how would it be if you told your friends that
19 you're coming to behavioral health to learn some life
20 skills? And when you're there, you get to use the computer
21 and play games." So she has yet to miss a session because
22 she comes and she frames it as a way of learning new things

1 and being able to have access to computers, which a lot of
2 the youth in the pueblo don't have access to.

3 And then finally, we collaborated with Youth Works, who
4 works with at-risk students and who are at risk for drugs
5 and alcohol or have been in the system or been incarcerated.
6 And that collaboration we gained -- we won a \$953,000 grant
7 where the youth is going to build 10 transitional units on
8 our property. We have to come up with the materials, but
9 they will learn from different experts in the community how
10 to build. And so, they will build our 10 transitional
11 housings for community members who are leaving treatment.
12 And one of the challenges of leaving treatment is you go
13 right back into the community that got you there in the
14 first place. And so, we're starting by addressing that
15 problem by making housing units using youth.

16 And the final thing is assessment. I get asked all the
17 time, "What are you," all the time. And what somebody
18 really wants to know is what's my culture, what's my
19 ethnicity. So in order to help people be comfortable, one
20 of the questions that I ask in an evaluation is, "In terms
21 of ethnic cultural identity, how do you identify"? And then
22 that's a way of, instead of imposing, "Are you Black, White,

1 Hispanic," I ask them to tell me how they identify.

2 Second, in terms of sexuality, "How do you identify,"
3 instead of asking, "Are you straight, or are you gay," how
4 do you identify. And third, we add -- I have added
5 "partnered and widowed," widowed being an area where if you
6 have lost your spouse or partner, nobody ever asks you that.
7 They say single, married, divorced. And nobody ever asks if
8 you're widowed or if you're partnered. So thank you very
9 much. And I'm really enjoying my time here.

10 MS. PAMELA S. HYDE: Thank you. That's great. Good
11 information. Good examples.

12 All right. Anybody? I'm going to take one or two more
13 comments.

14 And then -- yes, Stephanie, you want to go? And then
15 -- sorry, I don't know your name, but you could be next.

16 FEMALE SPEAKER: I know you'll be surprised that I'm
17 going to make some comments about women. Blessings to you,
18 Hortensia, for bringing up the women. Let's see.

19 Pete, when you're going to do the data collection on
20 the equity issues, are you going to separate the data on the
21 men and women?

22 MS. PAMELA S. HYDE: Stephanie, you need to stay right

1 next to the mike.

2 FEMALE SPEAKER: Pete, the data, when it's going to be
3 gathered for Lark's project?

4 MR. PETER DELANY: Lark, we have to talk about the
5 project because I'm a little behind the curve here.

6 MS. LARK HUANG: Okay. Well, I think in your survey
7 you collect gender.

8 MR. PETER DELANY: Yeah. We do. I mean, everything we
9 do, we cut and slice and dice by gender, by race, ethnicity.

10 FEMALE SPEAKER: Great. Okay. So I thought there was
11 going to be new data gathered on the behavioral health for
12 the Behavioral Health Equity project. But you already have
13 the data. And it is separated by men and women.

14 MR. PETER DELANY: Are we talking about NISTA?

15 MS. LARK HUANG: NISTA, yeah.

16 MR. PETER DELANY: Yeah, I mean, almost all of our
17 data, whether it's NISTA, DAWN or TADS is broken down by
18 race and gender.

19 FEMALE SPEAKER: Okay. Great. You know, a couple
20 comments about things have been said here. And when gender
21 becomes invisible -- it's interesting that Dr. Kim at
22 Dartmouth, he had a couple of consultants come and talk to

1 him about this binge drinking thing. And it was not me, but
2 colleagues of mine, who explained to him that they really
3 felt that if he wanted to do anything about binge drinking,
4 that they should focus on the young women, that if focusing
5 on the young men who did the majority of the binge drinking,
6 they didn't think behavior would be changed. It was too
7 hard to change behavior.

8 But if you could help convince the young women that
9 they did not want to tolerate that, that was going to be a
10 better place to direct prevention efforts. And also, the
11 young women had more to lose by binge drinking because of
12 the high rates of sexual abuse issue. Same thing with
13 smoking and prevention. You know, when they talk about we
14 know that adults don't start smoking, people 30, 40, 50.
15 But young people start smoking. But talking to young
16 people, boys talk about it as a sign of being an adult.
17 Girls talk about it in terms of weight control. So again,
18 prevention strategies have to be gendered. You have to
19 think about what the meaning of this is to everybody.

20 And I really like, Pam, when you talked about your
21 person who ran the Children's Bureau and they wanted, you
22 know, this for the children. And you said, "Put it out

1 throughout." And I think this is what I was trying to also
2 say yesterday, is SAMHSA used to have an initiative on women
3 and we were told, "Oh, let's get the women's issues
4 throughout." And that was my concern in the document, that
5 when we lost our women's initiative, we lost getting women's
6 voice and women's issues throughout." Thank you.

7 MS. PAMELA S. HYDE: Thanks, Stephanie.

8 I'm going to go to -- yeah, come up.

9 MS. PAT MORAZA: I'm Pat Moraza. I'm on the Council
10 with CSAT. And Cynthia and I have been working in the
11 prevention field together for 30 years. And I wish this
12 room today could see those colleagues that we've worked with
13 and experience today the excitement that we feel.

14 And, really, thank you, Fran, for taking the lead on
15 this. And I'd like to combine a bit what Terry said with
16 what Cynthia said in terms of it's now time to give it away
17 and give it away to the states. We know so much about what
18 works in prevention. We do not have to reinvent the wheel.
19 We do not have to design new programs. If we just use on
20 scale what we already have and then provide the money to
21 really evaluate the outcomes, I think that when we come back
22 here in a couple of years, we will see something we've never

1 seen before. Thank you.

2 MS. PAMELA S. HYDE: Yeah. Thanks a lot. We're really
3 pushing that there's research out there and prevention, too,
4 because there's a lot of people -- even, we heard this
5 yesterday, wasn't it, or the day before, where there are
6 some states who are saying we're getting rid of prevention
7 because we don't have any evidence that it works? It's
8 like, duh. So, yeah, that's good.

9 All right.

10 Arturo, you get the last comment here. And then we're
11 going to go to the whole committee for just a minute or two
12 about sort of next step.

13 MR. ARTURO GONZALES: I just wanted to thank Yolanda
14 for the wonderful six points that she brought up as an
15 example that's happening at the localities. And Dr. Briscoe
16 is a classic example of what we call a New Mexican as
17 opposed to New Mexican't.

18 [Laughter.]

19 MS. PAMELA S. HYDE: Thanks, Arturo. I think you can
20 see quite a bit of New Mexico influence here at this
21 meeting.

22 MS. CYNTHIA WAINSCOTT: Before we close, Pam, I have to

1 say hallelujah that we're putting staff out in the regions.
2 Hallelujah that the block grants are being attended to for
3 the changes they are. It's huge progress. Thank you.

4 MS. PAMELA S. HYDE: Yeah. Thank you, Stephanie. Your
5 perspective on what is a good step forward. It's always so
6 helpful. I really appreciate it.

7 So we have two or three things that are kind of on the
8 list for maybe next time. One is this federal partners
9 panel we talked about. We'll have to figure out what the
10 right topic is because there's a bunch of them we could do.

11 The other one that came up was looking at the
12 prevention grants. And, frankly, whether we actually move
13 in the direction we'd like Congress to move or not, we could
14 still step back and talk about what the states do in
15 prevention or don't. And that might be a useful
16 conversation, actually. We could get some of that from
17 block grant and some of that from other places. Those are
18 two things that have potentially come up.

19 Are there other things from the last couple of days
20 that you've heard about that you think would be useful?
21 There's always plenty to converse with you about, to
22 converse with you about.

1 Yes, Terry?

2 MR. TERRY CROSS: Well, I just wanted, as a child
3 advocate, I want to emphasize, you know, the importance of
4 language. And, I think, picking up on Stephanie's point
5 around women's issues, that sometimes when you write a
6 document like the strategic initiatives, things that are
7 deeply important to the organization may not surface. And
8 in the same way, the sentiment about women's issues, I think
9 children's issues are really important in that. So I just
10 want to get that on the table.

11 And kind of in that vein -- and I've been pushing this,
12 as I've mentioned. It has to do with the theory of change
13 and the coming into full implementation, in particular, the
14 systems of care. SAMHSA's made a tremendous contribution to
15 the field with this work. And that contribution is having
16 impact with families and children across the nation and the
17 families movement. And I mentioned I want to reiterate the
18 critical juncture from going from a ripe piece of fruit,
19 getting it to market. We don't want it to spoil.

20 So it's got to have some careful planning and attention
21 for taking this high degree of investment that's already
22 been made and moving that the final stages. And my sense is

1 that it's probably a three to five-year kind of how do you
2 really realize that. And just I want to make sure that that
3 message is loud and clear, to protect the investment that's
4 been made.

5 MS. PAMELA S. HYDE: Yeah, thanks, Terry. Some of the
6 things -- and you kind of heard us alluded to it. Some of
7 the things that we know we have learned a lot about we are
8 trying to bring "to scale," quote, unquote, by influencing
9 Medicaid. We're very clear that's what we're trying to do.
10 In other cases, what we've learned, we're trying to
11 influence a bunch of other players, whether it's ACF and
12 DOJ. And the trauma is a good example of that. The peer
13 support, frankly, is a good example of trying to influence
14 Medicaid.

15 Things like systems of care, we literally have a set of
16 dollars we are going to target toward bringing that to
17 scale. But that depends on Congress. I mean, if they take
18 it away, it won't be there to do. So in which case, we'll
19 have to think about how to continue to say and push,
20 especially systems of care where it's a multi-system
21 approach.

22 So in some ways, you know, there may be dollars for one

1 year or whatever. But there are other times when it's
2 really going to continue to be a conversation about how we
3 collaborate across systems for a long time. So those will
4 continue to be balances we have to work on.

5 But good point. Thanks.

6 All right. Anything else that anybody thinks we should
7 have just on the plate to think about for next time?

8 Yeah?

9 MS. HORTENSIA AMARO: So I know that we're an agency
10 moving in this new direction. I'm looking back, and I'm a
11 little bit worried about what's happening to or what will
12 happen, how the substance abuse treatment and mental health
13 treatment services will fare now that, you know, all that
14 we've shifted from those discretionary dollars funding them
15 directly. And I realize that's the direction.

16 But I'm wondering, do we have a pulse on how that's
17 going and how any way of assessing how many we'll be able to
18 successfully transition, you know, under health care reform
19 without SAMHSA funding and probably less support from the
20 states since more of the dollars will be going to
21 prevention. So I'm wondering. There's been years of
22 investing in a number of providers out there throughout the

1 country who have really grown their services through
2 SAMHSA's support. And so, what I'm thinking of is how will
3 they fare and how are they doing. And do we have any way of
4 assessing that over time?

5 MS. PAMELA S. HYDE: It's a good question. It's a
6 complex answer. I think, in some cases, we certainly have
7 data about how many of the grants have been able to maintain
8 what they started after our money went away. So we do have
9 that in most of the -- I'm looking at the center record.
10 Most of the programs we have that information. And it's
11 better in some than others.

12 But this broader issue of providers struggling between
13 now and when they can start building in 2014 for more people
14 or providers who, frankly, haven't been very used to billing
15 Medicaid or commercial insurance that are going to have to
16 make that shift. It's a more complicated question because
17 we are trying to do a lot of what John O'Brien calls pay
18 attention to the plumbing.

19 MS. HORTENSIA AMARO: Right.

20 MS. PAMELA S. HYDE: Because this isn't even about a
21 direction SAMHSA's setting. This is just the reality that
22 as we go forward, providers are going to have to

1 increasingly get their dollars from billing someone rather
2 than from a grant. That's just the nature of that beast.

3 So we're going to have to look at that in a much
4 broader way. It's just how providers are faring, you know,
5 in a larger sense. Yeah.

6 MS. HORTENSIA AMARO: Yeah, I guess my thought is that
7 wondering whether there is a system that we have in place to
8 sort of monitor how that's going or to be able to assess
9 whether there are -- big pieces of the system of care are
10 falling away because the agencies somehow aren't -- you
11 know? And is the responsibility of SAMHSA or contribution
12 that SAMHSA could make is having a way of assessing that
13 over time so that they can provide information on it.

14 And I suspect that a number of the agencies will make,
15 and a number -- and particularly the smaller agencies,
16 probably, in minority communities that provide culturally-
17 specific treatment that are not connected to a large system
18 of care may have a real problem. And so, that could
19 threaten, you know, the availability of certain types of
20 services for certain populations. So I realize that's where
21 it's all shifting. I'm saying, do we have any way of
22 monitoring and informing, you know, kind of?

1 MS. PAMELA S. HYDE: It's a great question. And I used
2 to get asked that question in Medicaid. It's this, how do
3 you monitor whether or not providers are being lost to the
4 system or not. I think the safe answer is, there's not any
5 one place where that's able to be monitored. I think some
6 of the provider organizations are trying to pay attention to
7 that. But it's a good question. And let's just take it as
8 a maybe it's something we could talk about next time.

9 MS. A. KATHRYN POWER: We're going to start having
10 these regional meetings, Pam, between now and the next time
11 that the Council meets so that we might be able to pull
12 John's experience from those states in some of those
13 regional meetings in the discussion about where the states
14 are.

15 MS. PAMELA S. HYDE: Yeah. Good point. What's
16 happening to providers, just generally, might be a good
17 conversation because as we've done the budget, we've really
18 made the argument that you cannot undercut the nation's
19 behavioral health system between now and 2014, or there'll
20 be nobody left in 2014 to bill. So we have made that
21 argument. But we don't really have data to back it up,
22 other than to say how many dollars are being lost. So the

1 real loss in the dollars is the \$2.2 billion just on the
2 mental health side alone from state dollars. It's not our
3 dollars that are being lost. It's state dollars, state and
4 county dollars.

5 And on the substance abuse side, we don't really have
6 that quantified yet. So anyway, good point. That's another
7 good topic.

8 Anything else that should be on our radars?

9 I've got Arturo and Pete. Anything you can't live
10 without saying? Because we really need to get to a closure
11 here.

12 Okay. Cool.

13 Thank you very much. These are always hugely good and
14 helpful discussions. And appreciate everybody who was in
15 the audience. And there are two people who are both still
16 here who wanted to talk to Lark. So she is here. I will
17 introduce you. Let's do that before we end, or when we end.
18 Thanks a lot.

19 MS. TOIAN VAUGHN: And you are reminded you may leave
20 your materials with your name badge, and we will mail the
21 materials to you.

22 [Whereupon, at 12:30 p.m., the meeting was adjourned.]

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