

**Substance Abuse and Mental Health Services
Administration
(SAMHSA)**

51st Meeting

SAMHSA National Advisory Council (NAC)

March 28, 2012

**Sugarloaf Conference Room
1 Choke Cherry Road
Rockville, Maryland**

**Proceedings by:
CASET Associates, Ltd.
Fairfax, Virginia 22030
(703)266-8402**

Table of Contents

PROCEEDINGS (8:30 a.m.)	1
Agenda Item: Call the 51st SAMHSA NAC Meeting to Order.....	1
Agenda Item: Welcome, Opening Remarks, Consideration of Minutes from the March 2011 SAMHSA NAC Meeting, Council Discussion, Reflections on Joint Council	1
Agenda Item: Council Discussion – Reflections on Join Council.....	7
Agenda Item: Performance Measures for Recovery.....	40
Agenda Item: Behavioral Health Disparities	70
AFTERNOON SESSION	96
Agenda item: Public Comment.....	96
Agenda Item: Other topics	96
Agenda Item: Closing Remarks and Adjournment.....	114

PROCEEDINGS (8:30 a.m.)

1

Agenda Item: Call the 51st SAMHSA NAC Meeting to Order

2

3 MS. WOOD: Good morning. I just want to thank all of you for being here
4 today, again. We appreciate the time that you have taken away from your jobs to be here
5 and work on these councils. It is very important to us. We appreciate your participation.

3

4

5

6 I just have a couple of announcements. I don't know if anyone has
7 decided to speak in the open session that has not previously registered to speak, but if you
8 do want to speak, there are comment cards at the tables. If you fill those out, we will
9 make sure that you get the opportunity to speak at the open public session.

6

7

8

9

10 If you are in attendance and you haven't signed in, please do so. There
11 should be a copy of the agenda, the member roster, and the bios on the registration table.

10

11

12

13

14

Agenda Item: Welcome, Opening Remarks, Consideration of Minutes

15

from the March 2011 SAMHSA NAC Meeting, Council Discussion,

16

Reflections on Joint Council

17

18 MS. HYDE: Thanks, Geretta, and good morning everybody. We have an
19 unusual situation. We don't usually have a quorum problem, but we do today. We are
20 waiting for a couple people who are on earlier time zones by about three hours. They
21 may not be quite up yet, but eventually we will get them on. We will hold things like
22 council minutes and things like that until we get to that point.

18

19

20

21

22

1 Usually, we start these meetings because we are all a little bit brain dead
2 by the time we get to this part in the process just reflecting a little bit about yesterday's
3 and some of you maybe participated in Monday's meetings. We had the Women's
4 Council on Monday and also the subcommittee on the Center for Mental Health Services,
5 the Subcommittee on Consumer Issues. We also had CSAT and CSAP both going on
6 Monday. Did any of you get the chance to participate in any of those or choose to do
7 that?

8 Why don't we do two seconds about the highlights that were out of those
9 meetings? Some of those reflect or relate to some of the issues we talked about
10 yesterday. Fran, can you say a word about what the CSAP, the Prevention Council, was
11 working on?

12 MS. HARDING: Good morning. We had a pretty lively discussion about
13 two major issues outside of budget, which I will start with. We have in prevention,
14 substance abuse and mental health disorder prevention. The group was anxious to
15 discuss the new proposed state grants. We had quite the discussion on moving substance
16 abuse, 20 percent set aside from the block grant, the substance abuse prevention
17 treatment block grant over and combining it with the Center for Prevention's
18 discretionary portfolio of grants and having that to offer.

19 We discussed the mental health state grant and how that would affect in a
20 positive, yet threatening way by some, to the mental health field overall. Then we had a
21 great support for the Behavioral Health Tribal Grant.

22 The other conversation we had was around the Strategic Initiative and how
23 they were quite surprised how SAMHSA has been able to move an agenda along pretty
24 quickly around combining the issues that are within the Strategic Initiative. We have

1 four goals. One goal surrounds working on emotional health across the country. The
2 other is underage drinking. Our third is suicide prevention in several high risk areas. Our
3 last is prescription drug misuse.

4 It is interesting to see that the last goal seemed to get most of the play
5 because right now prescription drug misuse is in the news a lot. It wasn't a surprise to
6 me. We spent a lot of time talking about that.

7 The last thing we discussed was the prevention paper that Pam alluded to
8 yesterday. We have a working draft. We had a slight discussion on an overview of that.
9 They have taken that home with them. In the first week in June, we are going to have a
10 phone conversation on their edits that they will send to us before the phone conversation.
11 We will have a meeting on the phone with the group to discuss where they think this
12 paper is going because Pam would like a copy of this, sort of a final working draft, so that
13 we can share it with the public. That is it.

14 MS. HYDE: Anybody have questions? I realize I probably should have
15 done introductions. I will come back to that. Let's go ahead and have questions.

16 MS. STEIN: This is just a thank you. We really appreciate the help from
17 the Center for Mental Health Services on our update of our State Suicide Plan. The
18 presentations were fabulous. We appreciate it.

19 MS. ENOMOTO: Fran, you mentioned that folks responded thinking that
20 the Mental Health State Prevention Grant was helpful yet threatening to the mental health
21 system or threatening to substance abuse prevention?

22 MS. HARDING: Threatening in a good way. We put it out there that it
23 would force some of our states to focus on having to look at the idea of doing prevention

1 of mental health disorders, rather than have the option the way they have now. That is
2 what they meant. It wasn't a negative, but another change element.

3 MS. HYDE: Other questions for Fran on what the prevention folks are
4 working on? Fran and her committee are obviously focused in the Center on substance
5 abuse prevention, but Fran, as a human being, leads and is a leader in ELT. ELT is our
6 Executive Leadership Team. She leads on our Strategic Initiative on Prevention, which is
7 both emotional health development, prevention of mental illness, as well as prevention of
8 substance abuse disorders. She does kind of both of those -- all of that.

9 Let's stop for a second. I will come back to sort of catching us up. I
10 really see your efforts with us, as you are a much smaller group, to help us sort of
11 synthesize what we are hearing from everybody else and helping us think at the Agency-
12 wide level sort of what we should be paying attention to and what advice you have about
13 stuff. Let's do a quick round of introductions.

14 I am Pam Hyde for -- I don't think there is anyone listening on the phone,
15 but just in case -- the Administrator of SAMHSA.

16 MS. WOOD: Geretta Wood, Committee Management Officer.

17 DR. HARDING: Fan Harding, Director for the Center of Substance
18 Abuse Prevention for SAMHSA.

19 MR. SPRINGGATE: Ben Springgate from the National Advisory Council
20 and a practicing internist and policy researcher.

21 DR. LEMELLE: Stephanie LeMelle from New York, Colombia
22 University, National Advisory Councilor.

23 DR. STEIN: Flo Stein from North Carolina from the Division of Mental
24 Health Developmental Disabilities and Substance Abuse Services.

1 DR. DELANEY: And you thought our acronyms were hard. Pete
2 Delaney, Center for Behavioral Health Statistics and Quality.

3 DR. ROTH: Dee Roth from Ohio, formerly Director of Research and
4 Evaluation for the Department of Mental Health.

5 DR. WONG: Marleen Wong, National Advisory Council, Assistant Dean,
6 University of Southern California.

7 MS. HUTCHINGS: I am not H. Wesley Clark. I am Linda Hutchings,
8 Special Assistant. I am just sitting in for him. He is running a little late.

9 DR. MARSH: I am not Paolo del Vecchio. I am Anna Marsh. I am
10 Deputy Director of the Center for Mental Health Services. Paolo cannot be with us
11 because he is chairing the CMHS Council. I am standing in for him today.

12 DR. ENOMOTO: Kana Enomoto, Principal Deputy SAMHSA.

13 DR. HYDE: Let's see who is in the -- Harriet, hello. Do you want to
14 come up and -- if there is nobody on the phone, we probably can hear. Just shout out
15 your name. Actually, let me introduce, but then I will let her introduce herself.

16 Yesterday, I introduced Miriam Delphin-Rittmon, who is the second
17 political, for whatever that means. Miriam is doing a lot of that work we were talking
18 about yesterday on service definitions and evidence analysis or assessment of the
19 evidence. You may have questions for her, but if you want to say a little bit about your
20 background, Miriam?

21 DR. DELPHIN-RITTMON: I am Miriam Delphin-Rittmon. I come to
22 SAMHSA by way of Connecticut. I worked as the Director of the Office of Multicultural
23 Affairs for the Connecticut Department of Mental Health and Addiction Services. I was

1 also Assistant Professor and Director of Cultural Competence in Health Disparities
2 Research and Consultation with the Yale program for Recovering Community Health.

3 I am glad to be onboard with SAMHSA, working on some of the service
4 definitions and assessing the evidence related to some of those services, doing some work
5 with Larke Huang around eliminating disparities in her new Office of Behavioral Health
6 Equity and to be doing some work with Pete Delany and Wes Clark, as well, around data
7 and evaluation related to potentially the common data platform. We are still working that
8 out. I am glad to be onboard.

9 MS. HYDE: Miriam, Dee asked a question yesterday about evaluation,
10 which, actually, I meant to go up and get the latest version of the paper and I forgot to do
11 that. Pete, sometime this morning could we grab the latest version of the paper? Do we
12 have the latest version of the paper?

13 DR. DELANEY: Yes. I do have the latest version of the paper.

14 MS. HYDE: It is probably a version we haven't seen, but that's okay. If
15 somebody could bring that down that would be great. I know Dee asked a question. It is
16 an issue. I don't know if we spent enough time talking yesterday about the way we are
17 sort of re-conceptualizing our work in evaluation and performance management. That
18 would be great.

19 Other folks in the room? Thanks, Miriam. You are welcome to stay at the
20 table if you like. I did that not only to just kill a few more minutes, but also just for you
21 to get a sense -- I mentioned it yesterday, but we have lots of staff and people who really
22 help support this effort. Getting to know a few of them is a good thing.

23

1 ***Agenda Item: Council Discussion – Reflections on Joint Council***

2 MS. HYDE: Let's go on with -- well, you can't say too much about
3 CMHS' committee because it is working today, but the Subcommittee?

4 DR. MARSH: I quickly checked their agenda because I wasn't able to
5 attend the meeting on Monday. The Subcommittee on Consumer and Survivor Issues
6 met on Monday. They like to meet before the CMHS Council to give them any
7 recommendations. Pam, I think you were there making a presentation. Paolo del
8 Vecchio was there. His position is as the Director of the Office of Consumer Affairs.
9 Now, he is, as you know, Acting Director of the Center for Mental Health Services. He
10 made a presentation. Wilma Townsend is acting in Paolo's position so she was there, as
11 well.

12 There was discussion of the Recovery Support Initiative, the regional
13 report structure, the new regional structure that we have, and funding of state consumer
14 groups.

15 MS. HYDE: Thank you. I was there for a few minutes, but it was really
16 more about -- when I was there is about questions they had or issues they had. They
17 raised everything from issues about trauma to issues about seniors. They had a whole
18 bunch of different things. The breadth of the things that the Subcommittee on Consumer
19 and Survivor Issues is amazing, really, in terms of what they are thinking about.

20 Do you have any information at all about the CSAT Advisory Committee?

21 MS. HUTCHINGS: I was only there part of the time because things were
22 happening upstairs about the exchange that happens next week. During the time that you
23 were there, they talked about how faith-based organizations participate and what role
24 they should play, the importance of faith as it applies sometimes to tribal organizations.

1 They also talked about work force, which is always an issue that comes up in the
2 treatment area.

3 The rest of the afternoon was spent, as I understand, a lot of our staff
4 letting them know what their involved in, kind of interacting and getting their input about
5 where they think their priorities should be and what things they, perhaps because we
6 spend our time here, giving them a perspective on what is happening out in the field, but I
7 am sure Dr. Clark can fill that in an awful lot more than I can.

8 MS. HYDE: All right. Thanks. Kana, do you want to talk about the
9 Women's Committee?

10 DR. ENOMOTO: The Advisory Committee for Women's Services had a
11 very rich conversation. We actually took the theme of schools and extended it to our
12 meeting as well. We had an experiential exercise where we sent out a DVD of a movie,
13 the movie Thirteen, and asked all of our members to watch it before they came.

14 We had a discussion about -- it is the story of a 13 year old girl, who sort
15 of makes the transition to middle school and runs into kind of a different, faster, more
16 troubled crowd and starts some very high risk behaviors. In our meeting, we talked
17 about, well, what role did the school play, could the schools play, did the Mom play? It
18 was a mom in recovery, who had friends also in recovery, and the challenges of kind of
19 the whole social network around that child.

20 It was a good conversation for us because I think it grounded us
21 specifically in issues of teenage girls and schools. Not all of us are working immediately
22 with that population.

23 We then had a presentation by Norma Finkelstein about mental health and
24 substance abuse treatment needs of adolescent girls and some of the theories around that

1 and as a particular example, what they are doing in Massachusetts with her Institute for
2 Healthcare and Recovery. Norma did mention that a lot more youth do have coverage
3 because of the health reform in Massachusetts and because of the lawsuit they have
4 virtually all children. 98 percent of adults have insurance.

5 It is changing the face of the provider systems and how they are having to
6 bill and are struggling to survive. What she noted in particular is that they have recovery
7 schools, they have residential, they have limited intensive out-patient, but that most of
8 their formal treatment systems had predominantly white clients. They were really
9 struggling to reach the girls of color.

10 What they have found -- they have started a new program, which involves
11 much more community outreach, home visits, meeting the girls where they are. Many
12 adolescent girls in general, particularly girls of color, either can't get to treatment because
13 they have responsibilities at home, they are primary childcare providers or because of
14 lack of transportation and the danger of moving across neighborhoods and going to
15 different areas of town. Their parents won't let them go to treatment far away from their
16 homes. That was an interesting program that they have developed.

17 We had a great presentation by Mary Louise Kelley from the
18 Administration of Children and Families about their recent IOM recommendations
19 around screening for women and girls around interpersonal violence. She did a review of
20 some of the science and some of their programming around screening and counseling for
21 interpersonal violence. We also started touching on how does that then relate to other
22 forms of violence and trauma, and SAMHSA's proposal for the grants for adult trauma
23 screening and intervention and where there is an opportunity to fill some of that
24 knowledge gap.

1 MS. HYDE: One of the things that -- I think you handed this out at the
2 women's group, right?

3 DR. ENOMOTO: Yes.

4 MS. HYDE: Do you want to say something about it?

5 DR. ENOMOTO: We handed out several things. We did hand out the
6 news release about health reform, providing 45 million women access to preventive
7 healthcare services. The IOM released its report on preventive clinical services for
8 women and girls and NHHS adopted those as guidelines. Under that, we are seeing 20
9 million women with private insurance and 25 million women with Medicare, who can
10 receive recommended preventive services with no cost-sharing. That was one of the
11 releases from the two years anniversary of the Affordable Care Act.

12 We also had the opportunity to release a CVSC report that showed that
13 women, who are on parole or probation are two times as likely to have a mental illness.

14 DR. AMARO: Hi. This is Hortensia.

15 MS. HYDE: Hortensia, hello. Thank you for being with us. I am going
16 to let Kana finish her thought and then we get the quorum established. Thank you for
17 being on the line.

18 DR. ENOMOTO: Finally, we did share with the committee some pending
19 legislation that is particularly relevant to women around eating disorders. They are both
20 on the House and the Senate side. There are some bills that are trying to raise the profile
21 and increase services and research around eating disorders.

22 MS. HYDE: All right, thank you. Any questions about the Women's
23 Group? We are still trying to sort out numbers of people that we need. This has not been
24 a problem before to reach quorum. We are struggling with that a little bit. We are

1 missing three of our appointees on this group. We could have three more people,
2 appointees. In the way the charter is written at the moment, it requires half of the number
3 that we could have, not half of the number that we have. That is a little difficult.

4 I think, actually, we need one more person besides Hortensia. We were
5 supposed to have three people on the phone. Thanks for joining us Hortensia. I know it
6 is really early out there. Oh, you're in Boston.

7 DR. AMARO: I'm in Boston. It is the same time.

8 MS. HYDE: I was actually thinking about Arturo. He is two hours
9 earlier.

10 DR. AMARO: Yes.

11 MS. HYDE: How long can you be with us?

12 DR. AMARO: Until about ten to ten?

13 MS. HYDE: Until about ten or a quarter to ten?

14 DR. AMARO: Yes, quarter to ten.

15 MS. HYDE: Hopefully, we will get one more person on the phone. What
16 we were doing, Hortensia, was we were just going through a little bit about the other
17 committees that met in the last couple days. We are just kind of jumping in.

18 DR. AMARA: I was listening to most of it yesterday.

19 MS. HYDE: Great. Thank you. The other committee that meets today is
20 the Tribal Technical Advisory Committee. We will be spending a little bit of time with
21 them this afternoon.

22 Let's just continue with some thoughts on your part about what you heard
23 yesterday or if you attended any of the other meetings or what you just heard that we are
24 spending time on. I was kind of reflecting yesterday about who you guys are. I really

1 appreciate Marleen spending time with us on the panel yesterday. I thought it was an
2 excellent panel. I thought it was really good.

3 All the way from that, which is a really big issue, to then a more specific
4 issue about the Disaster Distress Helpline that we just launched. I know you have had a
5 lot of issues in the Gulf region about disasters. A lot of that we learned to do out of the
6 latest one out there. I was thinking about you in that regard and just different things that
7 you are touching and working on. Do you have reactions to what you heard yesterday,
8 just the topics that we were dealing with?

9 I would be interested in not only your comments or thoughts about the big
10 picture stuff from health reform to very specific budget issues or administrative issues. I
11 would also like to ask your thoughts about what we discussed right at the end, which is
12 what do you think is next or should be next?

13 DR. LEMELLE: I think on the health reform issue, one of the things that
14 I am thinking a lot about is that, you know, if you look at the evidence base practices that
15 we have, both on the substance abuse side and the mental health side, the two that really
16 show that they work are supported housing and supported employment, in terms of
17 recidivism and recidivism in the criminal justice system.

18 As this new healthcare reimbursement is being created, I am not hearing
19 any talk about that. I know that it is not typically medicine or treatment in the sense that
20 substance abuse treatment or mental health treatment is treatment, but I think you can't
21 really get substance abuse treatment or mental health treatment if people don't have a
22 safe place to live and if they don't have something to do with their time.

23 I know it is tricky. I know it is Medicaid. I know it is third party payers.
24 I am wondering if SAMHSA as sort of a voice could emphasize that if there is a way to

1 allocate some funds in all of these changes towards supported employment and supported
2 housing as treatment for both substance abuse and mental health -- if there was a way to
3 fit that in somehow. I know it is tricky, but if there is a way to sort of have that overlay
4 some of the recommendations in the development of whatever we are going to have down
5 the line, it would be really helpful.

6 MS. HYDE: There actually is quite a bit we do about homelessness and
7 housing. Certainly, HHS is doing a lot of work with HUD around that. It doesn't
8 typically get talked about in health reform because health reform does tend to talk about
9 those things that are payable through insurance mechanisms.

10 There has actually been quite a bit of work that some of the states have
11 done about how to fund everything right up to rent in the housing arena. They can
12 provide all kinds of rehabilitation support, skill training, and case management. There
13 are lots of supports around that right up to the payment of the rent that they can do.

14 There are a couple of regs that are about to come out on the 1915I waiver
15 and the 1915K -- actually 1915I is the state plan amendment efforts. Anyway, those two
16 things are about to come out that may also provide additional opportunities. You are
17 right that we don't tend to talk about it in the health reform discussion because we tend to
18 focus on the billable services part of it.

19 DR. LEMELLE: I was just asking about the other side of it, which is the
20 supported employment side besides the housing side.

21 MS. HYDE: Supported employment is a little more difficult for
22 SAMHSA. We have some, but not as much work in that area. Anna, you may want to
23 talk about some that we do have. I think you have some supported employment work
24 going on, right?

1 DR. MARSH: I'm not aware of any.

2 MS. HYDE: None at this point?

3 DR. MARSH: I don't know of any discretionary grant programs. We
4 have had some conversations about it. Kana, are you aware of anything?

5 DR. ENOMOTO: I think we had some partnerships conceptually with
6 SSA in the past. We had to help participate in the demo study that they were doing, but
7 we have not had grants in the area of supported employment for some time. Supported
8 employment and supported housing are both key parts of the Good and Modern System
9 paper that John developed. When we talked about a good and modern system we did
10 include sort of all of those interventions that we know work well and serve the
11 populations we care about and then trying to assess from there what are the parts that
12 insurance will cover.

13 MS. HYDE: I have had the same problem, Stephanie, at the state level
14 when I was at a state level, of -- I think all of the evidence is pretty clear about supported
15 employment. The willingness to invest in the mental health and substance abuse system
16 in that, as opposed to in the labor system or in the economic system or in the commercial
17 system or whatever, has been lacking.

18 I think what your question raises for me is maybe this little broader issue
19 of we talk about SAMHSA as having a role of leadership and voice and yet we are often
20 standing on our grant programs to have that leadership and voice. It is a clear recognition
21 about where the grant making overlaps with the leadership and voice issue.

22 Now, Larke has done a fair amount of work with labor around kids and the
23 Department of Labor, trying to get young people into the workforce. They are finding
24 that substance abuse is one of the biggest difficulties. There is struggle with and around

1 that. She may have a perspective about that when she gets here. She has been dealing
2 with it more from the young people point of view.

3 I think you make a good point. We don't spend much time on that. We
4 do have grant programs in housing and homelessness that give us a little bit of a platform
5 to stand on with HUD. Actually, the person who is the Assistant Secretary for HUD right
6 now is Estelle Richmond, who came out of Pennsylvania, who has a behavior health
7 background. She is very supportive. She was here just a week ago meeting with Paolo,
8 who was there for us, and a bunch of people downtown to talk about how we could bring
9 Medicaid services and services from our shop and other places together with HUD.

10 They are doing some legal work at trying to get rid of some of the old
11 barriers to using vouchers or to having voucher set-asides for this population. I think
12 they have figured out a way to do that, particularly with a connection to Olmstead -- so
13 the Department of Justice and its work with the states. In HHS, the Office of Civil Rights
14 is kind of leading on the Olmstead issues. We are trying to be helpful about that.

15 We are actually just getting ready to do -- I think Allison Colker, who I
16 mentioned yesterday in the health reform arena, but is working with Paolo's shop and
17 others on putting together some policy academies out in the states around how to address
18 the Olmstead issues. That means bringing HUD and the mental health authorities and
19 substance abuse authorities all together. There is some discussion and work going on
20 around that, much more so than the employment point it sounds like.

21 DR. STEIN: You said what I was just going to say. I think some of what
22 you have done with home and community based waivers like extending it over to the
23 mental health side helps with some of this because there is a lot more employment

1 support in those kinds of support services that we have traditionally used for the IDD
2 population, but we can use for people leaving hospitals and things like that.

3 What you just said -- we are one of the states under investigation by the
4 Department of Justice for all the places that people with mental illness live. The Justice
5 Department, themselves, have been helping us with HUD to do some of the changes in
6 the rules so that we can use HUD vouchers more successfully for re-housing people,
7 which, of course, is what they are asking us to do. It is very slow going, but at least it is
8 going.

9 MS. HYDE: The good news in this administration is the Department of
10 Justice is very aggressive, but they are aggressive in getting something changed, not so
11 much in just dinging the states. They really see their role, I think, as being in a state
12 trying to say you have to do this differently and we will help bring resources to bear on
13 people to the table to help you figure out how to do that. That does seem to be a pretty
14 big opportunity.

15 We are not the lead on this by any means. The Office of Civil Rights and
16 Department of Justice and HUD really are. And ASPE, the Assistant Secretary for
17 Planning and Evaluation, has been charged by the Secretary at sort of helping to lead on
18 the housing issue, too. They are sort of the connection to HUD. There is another
19 meeting with Estelle over at HUD that is going on I believe this week. There is a lot of
20 work going on about that and a lot of stuff out in the states going on about that.

21 DR. LEMELLE: I guess I was thinking about it from the voice
22 perspective. We don't have to put money into it to talk about it. I think if the
23 opportunity is there -- I would put both of them out there, not just the housing, but the
24 employment, too.

1 MS. HYDE: I think the thing you are raising that is more compelling to
2 me because I know we have some stuff going on in the housing area is just the
3 employment stuff has been so hard. That and workforce have been hard for us to get our
4 hands around.

5 We, at one point, said let's get on the bandwagon that the President has for
6 all the right reasons about jobs, jobs, jobs and the economy, the economy, the economy.
7 Let's get on that about employment. We tried to do one program that was bringing
8 communities together with multiple sets of our grants to see if we could make an impact,
9 but it didn't get funded after three years. It got three years of funding and then Congress
10 didn't fund it anymore as part of the cuts.

11 That one is more compelling to me, in terms of a difficulty of how would
12 we do that as voice and leadership. It is something to think about. Thank you for raising
13 it.

14 DR. SPRINGGATE: Ben Springgate. My sense in listening to this
15 echoes one of your earlier comments, Pam, which is that the Department of Labor
16 appears to be the lead horse with regard to creating those types of employment
17 opportunities and taking the charge for the federal government. I have been co-directing
18 a Department of Labor funded community health worker training institute in Louisiana
19 for the last couple of years through Tulane University and Rand.

20 Even there it is a challenge to see that there is going to be continuation of
21 funding for that type of an activity, which, in theory, is to train lay personnel to be able
22 to, A, get reasonable jobs in community health where they can make an impact for things
23 like peer support and education things like that, who may not have a history of
24 employment. It is difficult to see if there is a lot of interest on both sides --

1 DR. AMARO: Pam, this is Hortensia. I don't know if I am speaking, but
2 I want you to know that I can't hear anything.

3 MS. HYDE: I can hear you usually, but then it goes in and out and I can
4 hardly hear anybody else. Let's let Ben try again here.

5 DR. SPRINGGATE: I will speak more loudly. I apologize for that. Can
6 you hear me now, Hortensia?

7 DR. AMARO: Yes, I can. I am not sure if it was that people weren't
8 speaking loudly or that the connection is going in and out.

9 DR. SPRINGGATE: I speak too softly. I am sorry. My sense is that,
10 given the pushback, as you were thinking about this regarding the Affordable Care Act,
11 given the various forces pushing against different aspects of that, it might be difficult to
12 find a way to integrate this into the ACA. There was another point, but I will come back
13 to it.

14 MS. HYDE: Just so folks know, Don Rosen should be joining us in a few
15 minutes. We will have about two seconds before Hortensia has to get off. We will try to
16 do the Council minutes during that period of time. Let's see -- Anna, you wanted to jump
17 in here and then we will go to Flo.

18 DR. MARSH: I was just going to say that I'm sure we do have some
19 employment support embedded within our various programs. It is just not the primary
20 focus of anything that we could report to you.

21 DR. STEIN: There is a national campaign going on called Employment
22 First. They have really been busy in our state trying to get us involved and committed to
23 lead efforts to improve employment. Of course, their position, just like Housing First, is
24 that you should do these things concurrently. You shouldn't treat people and try to get

1 them stable and then decide they need meaningful work and a place to live. You should
2 do all of that from the beginning.

3 MS. HYDE: Great. Thank you. Hortensia, I know you cannot be on very
4 long. If you have comments --

5 DR. AMARO: It's okay. I can stay on until about quarter to ten. I just
6 thought that the discussion and the presentations yesterday were terrific. I really like the
7 idea of the discussion -- the points brought up around integrating workforce and
8 children's services. I really like that direction.

9 I really appreciated that the Promise Neighborhood Initiatives were
10 discussed. I think those are really, at least from a public health perspective and thinking
11 about the whole concept of communities of opportunity and how neighborhoods and
12 opportunities that those offer or liabilities that those offer are so stenciled to the work we
13 do in mental health and substance abuse treatments.

14 We feed people all the time, who go through treatment, go back to their
15 communities and go back to housing where they can afford to live, which usually is in
16 very troubled communities. It not only jeopardizes their own recovery, but we are not
17 treating the underlying conditions that contribute to some of the mental health and
18 substance abuse problems we see once people come into treatment.

19 I don't know exactly how I would pick up a discussion about how
20 SAMHSA might think about moving some efforts or at least engage with some people
21 who are trying to do that. Perhaps you are already doing that, just not in the way that
22 makes it clear to me.

23 In all of these issues of working on economic development and
24 employment and housing in communities and in specific geographic areas, I think there is

1 a way to change the underlying risk and context that end up getting people into trouble
2 and at risk for the things that we later then deal with in treatment. Of course, if we can
3 change some of those underlying conditions, it would end up being a lot less costly to
4 treat people, considering all of the services that they end up needing and criminal justice
5 costs, et cetera. I just wanted to say a little bit more about my comment yesterday and
6 put that out there again.

7 MS. HYDE: Thanks, Hortensia. I think we got you disconnected
8 yesterday a little bit. Oh no, you're saying Don got disconnected. Thank you for the
9 comment, Hortensia. We were trying to get Don on for a minute so we could have
10 quorum. Reactions to what Hortensia said or, Marleen, I don't know how you felt about
11 both the panel yesterday, but also Hortensia's remarks about that.

12 DR. WONG: No, I would agree with Hortensia. I think she has a lot of
13 expertise around looking at prevention efforts from a community perspective. The whole
14 idea of having a Office of School Mental Health from a policy perspective and
15 SAMHSA's role in terms of truly shining a light on this area would be so helpful.

16 I think that schools are where the children are. I was thinking about just
17 the last year, in which I have received phone calls from people around at least the western
18 part of the country. There are several active suicide clusters that schools are trying to
19 deal with. There was a comment from someone in the office talking about she wanted to
20 point out that there were social networks that were emerging to help children who were
21 cutting.

22 What was startling to me is there are networks of troubled young people,
23 who are encouraging others to kill themselves. They get a picture of a doll that is
24 hanging and says just do it. There are unintended consequences of this idea that children

1 -- everyone has access to areas of the country and people that they wouldn't normally
2 come into contact with. Sometimes these social networks are far more compelling to
3 them because their issues are the same.

4 Also, I think that schools are struggling not only with the aftermath. That
5 certainly brings them to talking about troubled children who kill themselves. We just had
6 in Glendale this month a student who killed himself at school, which is unusual. We had
7 a child who killed himself in one of our LUSD schools, as well. The idea that -- they
8 hear the message that it is a contagion event and then they are in it and then child after
9 child or even a parent who commits suicide in the aftermath of a traumatic event, they are
10 just not prepared for the reality of that.

11 I think there is so much you could do, not only to bring together
12 stakeholders, who have those kinds of experiences, who would somehow, I think,
13 contribute to either a technical assistance center or a place where this experience
14 knowledge could be shared with others. I think there are things still going on in schools
15 that we continue to struggle with. I think SAMHSA could play such a great role in
16 providing leadership and that light to shine on those issues.

17 MS. HYDE: So the branch or the group of people who do our youth
18 violence work, some of which is related to the work with the schools, is in the same
19 division as the suicide efforts. They touch kids and young people, as well. We have kid
20 stuff in other places. I have to admit that the conversation yesterday about an Office of
21 School Health or School Mental Health or Behavioral Health or whatever we would call
22 that left me sort of trying to figure out how would we do that?

23 We already have Larke's role in doing cross-cutting children's issues. We
24 have children's issues all over the organization. You can't deal with children without

1 touching schools. They spend so much of their time there you almost can't. I was also
2 thinking about offices that we have are almost always designated by Congress or we
3 don't have them. We have a functional office like OPPI or like OMTO or OFR, but in
4 terms of a population office -- so the Office of Behavioral Health Equity was required by
5 Congress to be an Office of Minority Health. We chose to make it broader and different.
6 We have an Office of Indian Alcohol and Substance Abuse, which was also designated
7 by Congress.

8 I have been sort of for the last 24 hours sort of struggling with that
9 recommendation to see what you think that would get us or how would we do that? What
10 would that look like to you that would make a difference?

11 DR. WONG: I think that the audience is completely different. When I
12 think of SAMHSA I really do think of professional mental health folks and other people
13 under that umbrella coming to SAMHSA and looking for guidance in that regard.

14 I am not sure that educators will necessarily come to those websites and
15 access them. I think there are many things that need to be modified, specifically for the
16 educational environment. It is not easy to translate that material and say, well, how does
17 that affect the educator in the classroom or on the campus.

18 It sort of relates to the work I am doing with my colleagues at Rand and
19 UCLA Health Services Research Center. That is taking our evidence-based practices
20 around trauma and turning them literally into a curriculum that a teacher could teach. We
21 are just trying to push away from that more clinical approach, which we all feel very
22 comfortable with, but, you know, teachers don't. They are the ones that truly will do the
23 prevention.

1 MS. HYDE: Yes. Actually, we've been very effective and I think Larke
2 has been very effective -- she can talk about this when she comes because we are going to
3 deal with LGBT things today because it is LGBT health week, but she had done a great
4 set of work with teams. Rather than an office, she has teams working on different things
5 that are different aspects. That may be somewhat more effective for us.

6 I get your point about schools not necessarily coming to the Substance
7 Abuse and Mental Health Services Administration for information. In fact, I think our
8 work with education around the bullying issue may be worth -- it is a model that we
9 could look at. Kana, I think you were going to jump in here about something. Maybe
10 you could talk about that as well.

11 DR. ENOMOTO: I think that the spectrum of our portfolio is so broad
12 that sometimes having a specific office makes hinders the opportunities rather than
13 expands it. Having an Office of School Mental Health specifically, I could see the
14 appeal. On the other hand, I think substance abuse prevention really needs to be linked
15 with/happen in/connected with schools.

16 I think we have adolescent treatment programs, the suicide prevention, the
17 bullying, all of these other things happening in even children's systems of care also
18 connected with schools. Putting in an office sometimes isolates things. We could put the
19 word office over a door and it doesn't mean that we are going to have people or money to
20 do anything. Our ability to harness that and create a focused effort around schools or a
21 plan on sort of looking at our existing resources and how we are addressing schools in
22 those various ways, I think, is really worth some good thinking because children -- it is
23 where children are.

1 You can make the argument, well, why not an office on jail health or an
2 office on primary care or an office on hospitals or emergency rooms? There are lots of
3 offices we could create, but I think the argument for schools is that that is where the
4 majority -- I mean, that is where children are and it is a very big proportion of our
5 population. Again, maybe more of a cross-cutting team or developing a plan or an
6 inventory and then looking at strategically how can we do that might be more immediate,
7 as well as better meet the needs, rather than spending time and energy reorganizing and
8 setting up an office.

9 DR. WONG: You know we looked at Los Angeles, a unified school
10 district, as an example. It is the largest employer in the city of Los Angeles. At the time
11 that I worked there as Director of Mental Health, it employed 120,000 people. It had
12 750,000 children. When you add up the children, their parents, the employees, their
13 families, it literally reached 70 percent of the population in Los Angeles.

14 Just from a demographic approach, it became not only a place where
15 people came for help. Whether it was specifically around services, they came to the
16 school for help. Tragically, it also became the stage upon which people played out their
17 troubles -- where people came and killed their spouses. It was a place of employment as
18 well as a place of learning. We literally had to kind of become a little city all in itself
19 with employee assistance.

20 Maybe it is the size of it. That certainly may not be the experience of
21 many other towns and places across the United States. I guess, for me, that is why my
22 perspective is not whether it is an office or a team, but a place where educators and the
23 identity of the educator is so strong. I think when people say I am a school person it
24 resonates with people who have worked in schools. That is what I do. I deal with these

1 kids. As you said, it has to be looked at in terms of what your structure is at present and
2 how that would make sense with partnerships also with U.S. Department of Ed.

3 MS. HYDE: I think there are two things that I wanted to -- I know you
4 have heard us talking about the bullying website and other things that we have done, but
5 just as an example, again, Connie gets a lot of credit for this, but when I first came here
6 two and a half years ago we had a lot of work going on in developing content for our
7 website for middle schools principals. It was focused in a very clear way on schools and
8 school people.

9 We made a decision because HRSA has a major stop bullying effort and
10 has programming in that area as well and then there is some work out of the Assistant
11 Secretary for Planning and Evaluation around kids and youth that had some bullying
12 pieces to it -- anyway, long story short, we raised the issue and got over the last couple of
13 years, those three entities within HHS to come together.

14 This was no small feat. It is amazing how long it takes to get the
15 bureaucracy to let go and do something different. It took us a long time to do that. We
16 got the Assistant Secretary for Public Affairs involved as kind of the neutral convener of
17 that. I think it helped, frankly, for me. I talked to the Deputy Secretary -- it went that
18 high -- and said I have a million dollars worth of content here that I am willing to not
19 launch if we can give it to the right format and place and make this bigger inside HHS.

20 Again, long story short, we did that. There is now a team across HHS that
21 sort of manages it. Why don't you talk about this, Kana?

22 DR. ENOMOTO: The happy ending to this story is that we went from
23 four different scattered websites to one, a .gov website. Stopbullying.gov had a launch
24 last week. It is a joint effort of the Departments of Education and HHS with some Justice

1 involvement. The Federal Partners in Bullying are also involved. It is a work in
2 progress.

3 It has been run by and largely funded by HHS, but Ed is now partnering
4 and this year the Department of Education has offered to lead the editorial team on it.
5 We will hopefully be partnering with Education on providing some technical assistance
6 to support that. It is an example of how Education and HHS have interacted around
7 trying to get tailored content for schools and parents.

8 MS. HYDE: I want to come back to this because it is important advice
9 about what SAMHSA is going to do, but we have Don on. Don, thank you for joining us.

10 DR. ROSEN: Good morning. Sorry to not be there.

11 MS. HYDE: I appreciate that that can't always happen. Unfortunately,
12 we need you just to do some council business here really fast.

13 DR. ROSEN: Of course.

14 MS. HYDE: My understanding and remembrance of Robert's rules of
15 order and such is that once you get a quorum, unless someone argues otherwise, we can
16 have a quorum for the day. At this point, we have a quorum. We need to do the minutes.
17 The minutes you received, I believe, in the mail?

18 DR. ROSEN: I did.

19 MS. HYDE: These minutes were certified in accordance with the Federal
20 Advisory Committee's Act, the FACA regulations. Members were given the opportunity
21 to review and comment on the draft minutes. Members also received a copy of the
22 certified minutes. If you have any changes or additions, they will be incorporated into
23 this meeting's minutes. Does anyone have any comments or feedback?

24 DR. ROSEN: I have no changes to suggest.

1 MS. HYDE: Hortensia, do you have anything?

2 DR. AMARO: I have no changes.

3 MS. HYDE: Anyone around the table? If not, could I have a motion to
4 approve the minutes? Ben. Hortensia seconds. Any objections? Minutes are approved.
5 Thank you. We got that business done. We will continue with our quorum, unless
6 someone argues otherwise. Thank you very much for being on the phone and helping us
7 accomplish that.

8 We are going to look at the charter. Right now, the charter says that our
9 quorum has to be half plus one of the number we could have one here. We are missing
10 three members so we could have 12 and we only have nine at the moment. We are going
11 to work on this. Maybe we can figure out a way to have a majority of the people who we
12 have actually appoints. That might be easier. At the moment, we needed to get through
13 that. Thank you.

14 Back to the school issue, the bullying thing, I think, is not only an example
15 of what it took inside HHS, but then our ability to marry that with other Departments and
16 trying to figure out what the structures are in the federal government to have these kinds
17 of collaborations. You would think this would be easy, but it is not. It is hugely not.
18 You can imagine that being in Los Angeles. It is bigger than most cities, I think, the
19 school district. How many employees do you have?

20 DR. WONG: We had 120 thousand employees. The teachers were just
21 like 40,000. The rest of them were air condition guys, electricians --

22 MS. HYDE: What it takes to keep buildings going, yes. That is really
23 more mammoth than most of us can fathom, perhaps, but the point is managing the
24 bureaucracy or making bureaucracies move is really hard. I have been sort of thinking

1 about that from yesterday and what would we do with a focused attention on school
2 health.

3 I might also just say -- because I like to talk about it -- my son is an
4 Assistant Principal in a high school in Cincinnati. He and I frequently talk about
5 education and the issues in schools. He is not so much in the behavioral health world so
6 that is really not his world, but he is definitely in the teacher and administration world.
7 We have those conversations frequently. I appreciate the fact that you have to do
8 something that gets their attention and that they understand will be helpful to them.

9 The stuff we talked about yesterday when Michael Yudin was here about
10 the TA center that they are bringing up -- part of the reason we are trying to help them
11 rather than create our own is because we think school officials and principals and
12 teachers are going to pay more attention to an Education TA center than perhaps they
13 would to ours. We would rather help them with theirs.

14 DR. WONG: I think that would be a great way for SAMHSA to make a
15 significant contribution to their TA center. There isn't a place in Education, even in the
16 REMs, Readiness Emergency Management Initiative. They have a TA center as well, but
17 there isn't a School of Mental Health section.

18 I guess the reason I brought this up is that my question is who is
19 responsible for carrying out the recommendations of the President's new Freedom
20 Commission? There was very clearly a recommendation about expanding school mental
21 health services or mental health services in schools. Maybe it is the marriage of
22 SAMHSA and the U.S. Department of Ed, but somewhere where educators naturally
23 would go to say I have this -- and they think about mental health in two respects.

1 One is with these school shootings, these acts of targeted violence or
2 suicide prevention. I think those are really the big ones. Although, emerging out of New
3 Orleans, a group of educators went to the U.S. Department of Ed and asked for assistance
4 on cumulative trauma because they, themselves, were victims as well as the glue to keep
5 the community together. As they experienced the hurricanes -- they finally got over that
6 and then the oil spill. The teachers were just traumatized, themselves, you know
7 secondary vicarious trauma and were really asking for help about how they could sort of
8 reclaim themselves in order to go on and be the teachers that they were.

9 MS. HYDE: That point is incredibly well taken. Thank you. Any other
10 comments or reactions to this or to the discussion yesterday?

11 DR. SPRINGGATE: Ben Springgate. I thought it was very impressive
12 the amount of energy that you and your team have been putting into your re-organization
13 and the efforts that you took to sort of break that down for the assembled folks that were
14 listening. It has obviously been a tremendous undertaking.

15 MS. HYDE: Thank you. Again, Kana gets lots of credit for leading that
16 effort. Interestingly, I was telling Kana this morning we have a fair number of staff who
17 listened in to the thing yesterday. They either came in and out of the meeting or listen by
18 phone because they can sit at their desk and do that. I had a couple people stop me in the
19 hall, staff, who said that was really good and I liked that. They were listening as well. I
20 think it was helpful to them.

21 DR. SPRINGGATE: And if I may add one more thing from yesterday's
22 discussion, you mentioned it this morning already, the notion now that there will be a
23 distress line available for disaster-affected communities that will be advertised to them in
24 the short-term aftermath of the events that may occur. I think it will be very helpful, both

1 to help triage those people who may need longer term, more serious services, but also just
2 to diffuse some of the general anxiety and distress that really paralyzes people in the
3 short-term aftermath and creates a lot of at least interim dysfunction for people. I think
4 that is a terrific idea. I applaud you all and your efforts with other partners for putting
5 that in place.

6 MS. HYDE: Thanks. That idea really did come out of the Gulf
7 experience around BP. Because we got BP money, we were able to do that or pilot it. I
8 hope it came across clearly that that is now a proposal in our 2013 budget. If we don't
9 get that new money -- it is not a lot of money, but you have to have some. If we don't get
10 that, we are going to be struggling to try to figure out how to proceed with that.

11 The states are really embracing it. When we did it in the Gulf there was at
12 least one of the states who sort of said, well, we kind of have our own number. We
13 understand that, too. We don't want to intrude on what the local resources are. On the
14 other hand, when we presented it to the -- there were 46 of the 50 states on a phone call
15 that we did about a bunch of disaster stuff. They were really saying when is it, where is
16 it, when can I use it?

17 The idea of putting pressure on your own 800 number that may be dealing
18 with sort of regular, normal calls versus the potential flood of calls that could happen
19 very quickly and then recede is hard. For us to have a national way of dealing with that, I
20 think people really got on board with that. In fact, I think it is next week that NASMHPD
21 is actually holding some meetings with their members. It tends to be the mental health
22 folks who react first. The substance abuse folks, I think, get involved a little later. This
23 has really been working more with the NASMHPD folks in that.

1 Anyway, they seem to be embracing it. We really hope Congress funds it
2 so we can keep it going.

3 DR. STEIN: Did you say that you were thinking of linking it to the
4 lifeline?

5 MS. HYDE: It is linked to the lifeline in the sense of the same group runs
6 it. We made a choice to have a different number because we wanted to call it something
7 different. We wanted to call it a distress helpline. We used those terms because we did a
8 little focus group stuff to see what words should we use.

9 The other one, of course, is called 273-TALK, which, unless you have an
10 advertising campaign around that, which we do -- we have advertising work around that,
11 but that is really more focus around real distress and suicide and suicidality and other
12 kinds of things. We made a choice to have a separate number, but it is connected in the
13 same way through all the crisis lines.

14 DR. STEIN: So our state affiliate would kind of take that on?

15 MS. HYDE: Yes. By doing it that way, if there is specific information --
16 sometimes people will be distressed because they don't have information. I think that
17 was something that we learned real clearly out of the BP issue in the Gulf. People just
18 needed information. What is happening? When is this going to change? When is it
19 going to stop? It was an ongoing -- unlike an event and then you are doing clean-up and
20 reaction, it was an ongoing situation, which was in some ways more difficult, I think.
21 Ben may have more reaction to that.

22 DR. STEIN: I think it's a great idea because even our state emergency
23 response communication systems can get overwhelmed. Especially in a flood situation or

1 a big storm, you are not sure you have those communications. The more backup systems
2 and alternative systems the better.

3 The other thing I wanted to compliment you on is the work you have done
4 on redefining SAMHSA. This is the same struggle that states are having trying to find a
5 place for ourselves in health reform and changes and the growth of Medicaid. It is very
6 helpful -- the language, the ideas, and the ways you are thinking about it.

7 MS. HYDE: Ben did you want to say anymore?

8 DR. SPRINGGATE: Only briefly, I think it is one of the main benefits of
9 the proposed distress line is, for instance, after BP Deep Water Horizon spill in the Gulf,
10 it took about six months or a number of months before a line, appropriately staffed,
11 available for the entire Gulf was available. By having something that is ready year
12 round, you simply flip the switch and the number is on and the public announcements go
13 out on public radio or wherever it may be. Then whether it is Ohio tornadoes or an
14 earthquake or something major in our region or anywhere else in the country, something
15 can really begin quickly to be available for the affected population, which I think it very
16 helpful.

17 MS. HYDE: Yes. That is, again, something we learned out of that
18 experience. Frankly, it took a long time for SAMHSA to get involved down in the Gulf,
19 not the federal government so much per se. There was so much going on about whose
20 fault was this and who was going to take the lead in cleaning it up. There were all these
21 things going on that made it difficult for us to get in there and just deal with, regardless of
22 that, there is distress going on.

23 I think by having a distress line all the time we don't have to deal with
24 that. Whatever happens, we don't have to deal with is it a shooting? Is it an oil spill? Is

1 it a tornado? We can just be in there with the distress line. I have to give a lot of credit
2 to Nikki Lurie, who is the Assistant Secretary for Preparedness and Response. She was
3 extremely supportive of addressing the behavioral health issues in disasters and having us
4 at the table and being helpful about that. She is a great advocate for us.

5 I wanted to go back -- Dee you can come next, but I just want to make
6 sure that I say -- because we don't do it all the time -- we were focusing a lot yesterday
7 on the SAMHSA changes around OPPI because there are questions a lot of times about
8 OPPI's role and around the Deputy's role and all of that kind of stuff. Especially with
9 Joan coming in, I wanted to pay some attention to that, but I also want to acknowledge
10 there were other organizational shifts that also were difficult.

11 Daryl mentioned them a little bit, but she lost, if you will, or gave up a
12 policy kind of office. It went together with some other stuff that became OPPI. She
13 gained or took over a lot of work on grants and contracts management. Her Office of
14 Financial Resources was also kind of really different, having to figure out what those
15 roles were were different.

16 The Office of Management Technology and Operations was created. We
17 had an office that did some of that already, but it was created and the grants and
18 management stuff came out of that and went over to the financial resources. There was a
19 lot of stuff going on.

20 The Centers didn't change so much. Although, I also have to say that -- it
21 is more on hold than not happening -- we also had some discussions around the fact that
22 we have housing going on in all three centers and we have other kinds of things going on
23 in all three centers -- HIV/Aids going on in all three centers. There was some discussion
24 about how or whether to pull some of those together organizationally.

1 We, frankly, just got overtaken by how much change was going on. We
2 sort of said let's just leave that alone for a little while. At some point, we will come back
3 to that, at which point the staff cringes when they hear me say these things. At some
4 point, we will come back to that. Anyway, there was a lot of change going on.

5 DR. ROTH: From yesterday's meeting, I appreciated the update on the
6 Affordable Healthcare Act. I think it is really important for all of us to keep current with
7 that. It was interesting to me how much -- you drew the line. This has already happened.
8 This is what they are arguing about now and thinking about that and how that may play
9 out in the public. I think that -- just to anticipate what will be your last question of the
10 day, I think that we ought to have some kind of an update every meeting about where it is
11 moving, whatever it is the Supreme Court does, and then how behavioral health is
12 integrated with that.

13 MS. HYDE: Thanks for that comment. We both understand health
14 reform as an initiative for us. There are things we are working on that we have to do. It
15 is also this huge context. It is just changing the entire context in which we live and work.
16 We are having to pay much more attention to an insurance model.

17 The question, I think, that was asked yesterday by somebody -- Bill
18 McFarland, I think -- about how are insurance companies going to react? They are going
19 to be in a whole new world, too. Just trying to figure all of that out and, frankly, trying to
20 get expertise into SAMHSA, who have that background and insurance and Medicaid and
21 that kind of stuff is something that we keep trying to figure out what is the best way to
22 do.

23 I think of health reform as this much has already been done, the Supreme
24 Court is arguing over this much, and there is this much still to come. It is just huge. It is

1 growing about what it is going to have as an impact out there in the states on enrollment,
2 on enrollment systems. Again, my head wraps around, as everybody's does, their own
3 experience. My head wraps around if I were back in a state running those 53 offices that
4 are doing enrollment and eligibility, oh my God, what I would have to be doing to try to
5 get them ready for what is coming. How to coordinate those 53 offices with the state
6 insurance department, with the high risk pool? My head just goes nuts trying to think
7 about this. Luckily, I am not out there having to do this.

8 At any rate, it will be interesting. Then reading the headlines this morning
9 on what the pundits think happened in the Supreme Court yesterday and listening to some
10 follow-up phone calls that we have been having each day with the Secretary. She is
11 there. She is there sitting in the court, listening to the arguments. We have been having
12 those each day, just a follow-up with her and the attorneys, listening to what their
13 perspectives are. It is very interesting. They are different, as you might imagine.

14 We will keep having some updates about that. If you have thoughts about
15 pieces that you think are more important than others -- what I gave you yesterday was
16 sort of a big lay of the land. It is really too much to absorb in one day or one hour
17 session. Other comments? Do you have the evaluation thing you want to hand out, Pete?
18 I thought I saw you come in with that.

19 My question was, is this the final, final paper? Kana says, well, I don't
20 think you've read it yet. I guess that means it is the final, final paper.

21 DR. DELANY: I think it is sort of the pre-Pam final paper. It is pre-
22 decisional, which is on it, and I have it date controlled.

23 MS. HYDE: Pre-decisional generally means we don't hand it out yet.

1 DR. DELANY: For those of you who don't know, I kind of had problems
2 putting dates on papers, but now I don't because I told my computer to do it and it does it
3 for me. I don't think talking about the common data platform will take that whole hour.
4 If we want to have more discussion about the evaluation, we can.

5 MS. HYDE: Yes. It is just the Council. People beyond the Council, we
6 are not supposed to hand it out to. Are there any other questions about -- we will just
7 move into the common data platform. We will take a break and do that.

8 Anything else from yesterday or any reflections about further things that
9 you think we should have on the Joint Council's plate? We continue to try to struggle
10 with if we bring everybody together, then the good news is everybody hears the same
11 thing. The bad news is the middle day is just deadly in the sense of I know you all are
12 just brain dead by the end. We probably are as well. We are trying to think of ways we
13 can keep people working on the similar issues as they go out into or come back from their
14 individual councils.

15 I always like to have this one afterwards because I like to hear your
16 perspectives as a sort of synthesizer. Do you have thoughts about what you heard, in
17 terms of what is next and what you think should be paid attention to next? We can come
18 back to this issue at the end of our time today, which is about 1:00-1:45 PM today. Any
19 thoughts now?

20 DR. LEMELLE: Just one thought as an over --- sort of an umbrella issue,
21 which is the criminal justice system and folks going in and out of the criminal justice
22 system on all levels -- women, children, adults, substance abuse, mental health. It is just
23 sort of everywhere. Again, even thinking about how that is going to be impacted with the
24 health care reform and how those folks are either going to be picked up by the new health

1 care reform or dropped off of it as they go in and out of the criminal justice system and
2 what impact that has on the larger systems, I think, is something that we may want to
3 look at as this is evolving.

4 MS. HYDE: Anything else that people have a reaction about?

5 DR. STEIN: I think that was a great idea. There is a lot of work that has
6 been going on with NACO and Coaches and other groups, working particularly on that
7 issue. We might be able to get them to come and share what they have been doing.

8 MS. HYDE: Okay. Kana?

9 DR. ENOMOTO: I was also wondering about -- Pam had mentioned the
10 NASMHPD number that they used. I know NASMHPD and NASDSE both had a
11 briefing on the Hill about the context of state government shortfalls and the challenges
12 that behavioral health is experiencing at that level. I thought perhaps we could have --
13 and then we just came back from the territories. Perhaps we could have a session on
14 state/tribal/territorial sort of government perspective.

15 Similar to how we had the session on schools where we had members
16 participating, we could have a few who are state/tribal/territorial government
17 representatives talk about what is the context for our types of programs in the work we
18 are doing that you are dealing with. That is really advisory to help us understand what is
19 happening out there. That was an idea of a session.

20 DR. WONG: Since we're coming to the end of this part of it, I just want
21 to make a comment outside of the work that we might be focused on here. That is I was
22 very interested to hear about your trip to Asia, yes?

23 DR. ENOMOTO: Outer Pacific.

1 DR. WONG: Okay. In terms of what's going on internationally after the
2 earthquakes in China and Japan, those countries and much of Asia is very much focused
3 on what you all are doing and looking for ways in which to learn about disaster response
4 and recovery. It is a huge issue now that they are trying to incorporate not only in terms
5 of government and schools, but also to incorporate and develop a curriculum within their
6 universities.

7 I just saw what you were talking about having a role. I know there are
8 government limitation, but just to be aware that that is big over there, right now.

9 DR. ENOMOTO: FEMA did ask us to send someone to a conference in
10 China on disaster management. We did send somebody to brief them, I think, on our
11 RCCP program.

12 MS. HYDE: Anybody else? Yes, Flo?

13 DR. STEIN: There was a little article in USA Today this morning about
14 the wash up from the tsunami on the West Coast. They weren't expecting it to start
15 arriving yet, but it is already arriving. It is contaminated material. It is just a whole
16 different kind of issue that we have never really thought about before.

17 MS. HYDE: Yes. One of the issues around the disaster distress line --
18 and we have no interest or no capacity in it being the information source. Yet, you can
19 imagine -- in fact, after the Japan tsunami and all of that stuff, there was a lot of concern
20 on the West Coast about food and about other kinds of things. There was information
21 about that that was useful to put people's minds to rest or things that they really shouldn't
22 eat or whatever.

23 It seemed to me that the distress helpline could be also armed with some
24 of that information so if people are calling in distress about that and really being anxious

1 about the, just a little information also might be able to be helpful. I don't mean to
2 downplay that or make that insignificant. I think that is a big deal. Yet, we are trying to
3 walk a fine line here with that line, not having it become the information line and having
4 everybody calling and saying what is the information about X, Y, and Z because there is
5 no way we could do that.

6 DR. LEMELLE: The question was whether on the help line, if there were
7 referrals to FEMA or to other sources where you could get more information?

8 MS. HYDE: Yes. There do have that kind of information. That is the
9 thing -- we can do that kind of information that is more general. If there is specific stuff
10 about a specific disaster, we can get that information out. Anyway, good point.

11 Anything else on this issue of what next or what your thoughts were from
12 that? You may have other thoughts about that after we go through a couple more things
13 today. We are going to talk about the common data platform. We are going to talk about
14 LGBT health disparities.

15 We consistently get asked about disparities. We thought this time because
16 it just happened to coincide with this and the Department is doing a whole lot of work
17 with this that we would have you hear a little bit about LGBT health work. We also
18 thought that there might be a way that we could talk about disparities in a different way.

19 We have had Larke present several times, but it might be more of a --
20 again, there are some folks -- I don't think anybody in the room right now, but there were
21 two or three people raising issues yesterday about, for example, the role of evidence-
22 based practices in minority communities or in communities that typically experience
23 disparities. I think that might be an interesting almost debate because there is a little bit
24 of different perspectives about that among our advisors. That might be a panel as well.

1 Since people keep asking us about the disparities issue, we might deal with it a slightly
2 different way. That was a thought as well.

3 Do you have any final thoughts on this about what next? All right, if you
4 are ready for a break, let's do that. It is about five after 10:00 AM. We will come back
5 and start about -- let's give you the full 15 minutes -- so about 10:20 AM, we will start up
6 again. Thanks.

7 (Break)

8

9 ***Agenda Item: Performance Measures for Recovery***

10 DR. DELANY: I wanted to give you a brief update on the common data
11 platform. One of the things we are trying to do with this is obviously to accelerate the
12 process of discovery and improve patient care. Also, there is a big thing -- I don't know
13 if anyone has heard -- open.gov. There is a piece from the President that says we are
14 going to get as much data out there as possible.

15 There is a lot we are trying to do with this one system. I don't think
16 anything we are trying to do in any of the initiatives is just a single item. We are really
17 covering a lot of bases, which is why all of the leads are having to work with each other
18 all of the time because there is so much interlap and overlay about everything, which is a
19 good thing. I am also learning collaboration takes more time, which is not good for
20 impatient people like me.

21 Let me talk a little bit about some of the reason and need and motivation.
22 Part of this, again, as I said, is kind of a key directive from the President's strategy to
23 accelerate the process of discovery and improve patient care. Part of this whole message
24 is we are not just going to have data systems that we use internally. We will have data

1 systems that we use to help drive what we are doing and use evidence to make our
2 decisions.

3 At the endpoint, we are going to have dashboards or whatever you want to
4 call them -- basically, graphic displays -- so that eventually the grantees get their data
5 back, but also eventually the public has to be able to look at our data. It is a little bit
6 tricky because you have to make sure you protect confidentiality and all of that, but the
7 idea is to create opportunities for both internal and external stakeholders to work together
8 towards better solutions. That is the goal of this thing so that the data is -- everybody is
9 playing on the same field. Everybody has the same information. And we are working
10 together.

11 The background and where we have come from. Pam tasked me with --
12 actually, it started with Rick and then Pam re-tasked the Center, at that point OAS, now
13 CBIS, to develop a uniform collection and to work with the Centers. She gave some
14 various goals. One of them is the ability to analyze the programs at various levels and the
15 state program community level data within it to provide each Center and each staff
16 member working on programs some real-time tailored information about the progress of
17 the activities within our grantees and then to provide data back to the grantees to support
18 efficient and effective implementation of projects.

19 One of the things is we are trying to give the grantees back their own data
20 to say take a look at this, use this information that you have been feeding us -- that has
21 been, historically, an issue from grantees over a long time. Even when I was at NIH, they
22 would give us all of this information, but then what are we doing with it and how can
23 they use their own information? The idea was to implement the uniform data collection
24 and reporting system for entering of discretionary grants. We are still working on the

1 block grant component idea. Then basically pull things together into one common
2 strategy.

3 There are two things, additionally. One is there is a push from the
4 administration to stop having so many contracts. It is to kind of reduce and create some
5 efficiency. This also helps with that. Then this also really does help with the open.gov
6 because as we move forward we have the capacity to allow the grantees to use it, but then
7 the public can have access to data down the road so that they can see how SAMHSA is
8 taking their public health investments and making wise choices.

9 Of course, I realize that there are some people that no matter what we put
10 the data out, they are not going to think it is a wise choice, but that is a different issue. I
11 can think of some people.

12 What is the progress we have made? Well, we have done some
13 collaboration with our internal stakeholders over time. That started, but what we did was
14 with Pam and Kana's guidance and leadership is we have also engaged MITRE, which is
15 a federally funded research and development corporation. I want that kind of initial after
16 my name.

17 What they have done is sort of come in and done some information
18 gathering within the Center. First, we engaged 12 of the leaders and nine focus groups
19 with about 50-60 people in each group. They have been helping us think about some of
20 the issues going on. We had some snags. Let's be honest. We hit some snags and we
21 were moving on it.

22 Some of their findings were pretty clear. The mission and vision was kind
23 of misunderstood. What we did find is that through that process is a lot of the key
24 stakeholders -- these were some of the key workers, who were going to be using this

1 process, as well as some of the leaders -- had a better understanding, but there were some
2 reservations about it. Part of it is, you know, is everybody going to get what they need
3 out of it?

4 I think at this point we are really poised for collaboration. We are really
5 moving forward. That phase of the MITRE is done. We had developed a statement of
6 work before, but we are going to be revising that based on some of these issues.

7 Where are we now? We have engaged MITRE in another contract to help
8 us do some additional things. Part of what they are going to do is they are going to do an
9 environmental scan. They have already met with ACF, CDC, NIH, and CBIS to see the
10 similar types of data systems that they are using. They are also meeting with HRSA,
11 DHS, IHS, and Bureau of Indian Affairs and -- this is a new one to me -- American
12 Association of State Highway and Transportation Officials.

13 By the way, all of you who get all of the initials by the end of this day --
14 and this includes yesterday -- will get a free copy of our Findings Manual. They are
15 doing that environmental scan and looking at these, both internal systems, the three
16 systems -- the SAIS system, which is CSAT, PRMTS, which is CSAPs, and then the
17 TRAC, which is CMHS'. They have already met with the people in charge of those
18 systems and looked at the type of functions and variability within the systems as well as
19 the data.

20 They are going to be working on developing and assessing alternatives, for
21 example, looking at cloud technology, which has a big push from the administration to
22 use that. There is a lot of fear and probably some legitimate fear, given a couple of big
23 things that blew up about people breaching the cloud in a couple of places. They are
24 looking at that.

1 They are going to be working with each of the Center staff and also the
2 technological things that are available to look at what kind of requirements this new
3 common data platform is going to need, but also what kind of things we want it to do.
4 Remember, there is going to be some phased input. We will start with the discretionary.
5 We probably will be moving to block grants.

6 What kind of bells and whistles do we need to have? What kind of
7 flexibility do we need in the system? How do we get common elements that everybody
8 uses, but also make sure that the unique elements for some of the programs that are not
9 necessarily going to have the same common issues get put in? How are we able to add
10 measures as well as take measures off?

11 One of the things that is also coming down from OMB has been
12 repeatedly how much data do you really need to run you program? What do you need?
13 How do you justify it? What do you need to move the program forward? If you are
14 going to add measures, what measures do you need to keep? Do they all need to stay?

15 I think this is common across -- I don't know how many people looked at
16 Healthy People 2020, but what started out as this little thing has become this mammoth,
17 huge dataset in and of itself. There is a question of how many more measures of data --
18 how many more pieces is Healthy People 2020? I have learned that if you are involved
19 in the 2020 from the Executive Committee, more data is better, but not necessarily how
20 you want to use the data.

21 That is a question every time I go to OMB is -- you have been to a 2020
22 meeting, but the question that OMB asks me at every turn is what are you using that data
23 for? That is one of the things is we are working with the Centers to understand what are
24 the data needs they have, what might they need in the future, and setting up processes so

1 that if we add something, are there other things we will be removing? One of the keys
2 things that will be integrated into the structure, similar to the evaluation, is we will be
3 integrating an ongoing working group that is internal so we are starting to looking at
4 some of those ideas.

5 The other thing is what kind of an approach that involves both thinking
6 about the industry and the design and the development of this project. Do we do an open
7 source? Do we use what are called IDIQs, which are existing -- people have already bid
8 to be a part of it? Do we look at which IDIQ? Do we use a performance contract? Do
9 we use a cost plus fixed fees? They are looking at different mechanisms in the type of
10 approach.

11 Where are we going? Right now, even as we are working through all of
12 this, we are beginning to put the OMB requirements together. We are working on the
13 business needs statement, the business case, the project charter, the management plan, the
14 statement of work. We have one, but we are working on refining it. That will obviously
15 continue to be refined as we go through with this.

16 The goals are the issue contract in fiscal year 2013 or even a little bit
17 earlier if we get there. We are looking towards early 2013. Then have a fully functional
18 system by 2014, which has required a lot of fun stuff with the budget. Daryl and I were
19 best buddies for about two weeks on this, but we are getting there.

20 That is kind of where we are. There is a lot going on. Right now, we are
21 really focused on the technical aspects of working with the Center staff to really get
22 through all of the technical aspects and looking at the functionality of the system,
23 matching functionality, and enhancing functionality. I think it is going to be key to look
24 at some of the other systems that aren't us to see what they are doing. A lot of people

1 have already solved this problem that we are going into -- so to see how they have done
2 it.

3 Let me first just give you a quick -- I want to introduce Owen. He joined
4 my staff last year. He is the project lead. He has been terrific in building some
5 relationships and helping me move this forward. That is it. That was my quick intro.
6 Questions?

7 DR. ROTH: If you could go back to your slide background "where we
8 have come from", further back, further back, that --

9 MS. HYDE: That's exactly the slide I knew you were going to go back to,
10 Dee.

11 DR. ROTH: Could you do the acronym? What do those stand for and
12 what do they mean?

13 DR. DELANEY: SAIS is Rick. I don't know what it stands for. It is
14 Substance Abuse Information System. TRAC is Transformation Accountability.
15 PMRTS -- they keep changing the name of it, Prevention Management Reporting and
16 Training System. Then CDP is the simplest. It is the Common Data Platform. Actually,
17 just by doing one contract we have improved the acronym. Those are systems by which
18 we collect our GPRA data mostly on out discretionary grants.

19 MS. HYDE: Rich, they may not know what GPRA is.

20 DR. DELANEY: Government Performance and Results Act. This thing -
21 - really, the new platform has to do a number of things. One, it has to be useful to the
22 agency, not only to manage this work, but to report. That is why we are working so hard
23 to figure out what elements we can do in common, what has to be unique, and what will

1 help us figure out what we are doing? We have to use this also to report GPRA. It is an
2 integrative process.

3 The other thing is that one of the byproducts of this is that no matter where
4 you enter -- because a lot of states will get grants from different components, but
5 wherever you enter, it is going to look the same. There is going to be a common look and
6 feel. Also, we need to be able to give real-time information about what is going on in the
7 system so they can help inform their management about what is going on and what
8 should be done.

9 Managers need to be able to look across their systems and say what is
10 going on across my system. Eventually, one of the things I was told at the beginning is I
11 want to be able to look across all of these systems. At the senior level, in IOA, they need
12 to be able to look across at cross-cutting issues. Not only for GPRA, but we are going to
13 have to slice and dice this data for OBHE, Office of Behavioral Health Equity, because
14 we have to have a report on race/ethnicity/et cetera and how we are doing on those
15 things.

16 MS. HYDE: So let me take this up just another 30,000 feet or another
17 20,000 feet to get to 30,000 feet and then open it for you to ask questions. SAMHSA has
18 undertaken this National Behavioral Health Quality Framework. In that framework --
19 this is the part that drive Pete nuts when I talk about this -- in that framework, we are
20 trying to put together the things that we think we would recommend to the field or guide
21 the field or require the field or whatever you want to call it -- in different ways it is
22 different things -- to measure whether we are making a difference, whether there is
23 quality out there, whether programs are good, whether services are good, and whether we
24 are making any difference.

1 We have a set of -- we have six goals in that quality framework. Within
2 those six goals -- or in each of those six goals, we are concerned about what SAMHSA
3 does, the things we fund, and what kind of outcomes or quality we might have in that.

4 We have a set of concerns about sort of systems and practitioners, which
5 could be funded by Medicaid, by insurance, by self-pay, any number of ways. The point
6 is we might be able to impact it within HHS or federal government or whatever. We
7 might not be able to impact it, but nevertheless a set of quality issues there.

8 Then there is a set of population-based data that says, okay, we did really
9 great quality services that SAMHSA paid for, we did really great quality services that
10 Medicaid and private insurance paid for, but did we bring down the number of kids using
11 illicit drugs? Did we really make a difference in that sense?

12 The quality framework is trying to look at all of these things. GPRA,
13 which is the government accountability system has been under a significant amount of
14 discussion because this administration wants to limit the number of GPRA measures that
15 we focus on and do more cross-cutting kinds of things. This resonated for SAMHSA
16 because we were already -- we had something like -- I think we had more GPRA
17 measures than any other operating division even though we are one of the smallest. We
18 had like 190 or something. In one year, we went from 190 down to 100 or so, give or
19 take. We are still trying to push that down further because with every program we had
20 we would add 17 more measures.

21 We have been working on all of that over the past couple of years. At the
22 Department level, at the HHS level, they have been trying to say, well, what are the
23 cross-cutting things that we might care about as a whole Department, regardless of which

1 operating division you are sitting in? They are doing some of that kind of cross-cutting
2 look.

3 All of that is going on. These systems really are systems that have to do
4 with -- for the most part are discretionary programs. The 25 percent of our budget or
5 even less, really, because in that 25 percent is also surveillance and other kinds of stuff --
6 anyway, the portion of our budget that is giving out grants, not block grants, giving out
7 those kinds of things, this is really what we use to track what is going on in them.

8 We had three different systems for that. We are trying to pull together one
9 system for that. It needs to be able to track consistently across those different grants
10 because right now those three different systems are at different levels of detail,
11 development, et cetera.

12 We also have this block grant thing. 75 percent of our money goes out to
13 the states. We do require the states to give us some feedback and some data back about
14 that, but they give it to us in very different ways. The substance abuse block grant is
15 much more individually based or at least the states are able to collect it that way. In the
16 mental health block grant, it is collected at the states in different ways, but aggregated up
17 to us in a different way. I could say a lot more detail about that, but the point is that they
18 are different as well.

19 In the program integrity effort that actually was mentioned yesterday,
20 Daryl mentioned it yesterday, one of the things we put on the table as a program integrity
21 risk was the way we were able to collect data about the mental health block grant at a less
22 granular level. There has been work that CMHS has been doing with some states and
23 other things about trying to get that better.

1 There is a point to me telling you all of this stuff, which is we are also
2 trying in the block grant to look at some commonality in ways that we would ask states to
3 report. That is a separate thing, but we want to make sure that if we ask our discretionary
4 grants to report in a certain way about something, we don't want to have a completely
5 different way that we want the block grants to report. Yet, that is a much bigger bucket
6 of issues that we are dealing with. Pete's shop is also helping us deal with the block
7 grant side of it, too.

8 There is a whole lot of stuff going on here is my point. There is a lot of
9 stuff in play about the National Quality Framework. There is a lot of stuff in play about
10 pulling together the common data platform. There is a lot of stuff in play about how we
11 are asking states or working with states to report about their use of block grants. All of
12 this stuff has to be consistent and framed in a way that gets appropriately to the National
13 Quality and Outcomes Framework that we are trying to create.

14 That is the context in which this particular project is sitting to get done.
15 Did I say that right? Would you guys add anything from the Centers about how that
16 plays from your point of view? With that, open up the floor for comments or questions.
17 Dee, did you have more? You have been through this in a bigger way.

18 DR. ROTH: I definitely have more, but I will let somebody else ask a
19 question. I thought the context thing was very helpful, by the way.

20 DR. WONG: I'm a PI for one of your grants with the National Child
21 Traumatic Stress Network. I appreciate the bigger picture. I think I will be far less
22 resentful about having to complete that portion of the track now that I know how that all
23 fits together. Over the years, it has changed again. I get it now. Thank you.

1 MS. HYDE: Well at one point when we were redoing the GPRA stuff, we
2 went as simple as -- or my head -- I will make that an I statement -- my head went as
3 simple as, okay, we have 190 things we are collecting. Maybe in each program we just
4 need to say what is the output? So how many people got served or how many people did
5 we touch, whatever the output is? What is a common outcome, which we took sort of the
6 recovery construct that we were trying to look at? And then what is the specific
7 outcome? If a grant is about drug courts, for example, it is a very specific outcome we
8 are looking at.

9 We were just trying to frame it at that way big a level. Now, we might
10 collect all kinds of other things or you might collect all kinds of other things at a grantee
11 level because you want to know in your community or your grant or whatever -- it is also
12 even possible that for reasons of research or evaluation or whatever that you might collect
13 other thing, but what are the things that we really need to say back to congress?

14 What are the things we need to be able to say to the field? What are the
15 things that we need to be able to say? Especially when you heard Kana talking yesterday
16 about the Theory of Change and really trying to push the field, what do we need to know
17 about this new initiative or this new grant program to say did it make enough of a
18 difference that we want it to become something we flip the whole switch on with the light
19 analogy?

20 It is really easy to collect 5,000 things. They are interesting to know. You
21 can go more and more and more. We have one program that I think has been in existence
22 for 20 years or however long -- a long time. We have been evaluating it. We keep
23 delving more and more into the details of what can we learn about. We are learning great
24 things, but in a tight budget time we have to struggle to say, well, is learning more and

1 more detail about that program more important or should we stay up at the higher level
2 and try to say, okay, after 20 years, we have proved over and over and over again that this
3 program will produce these three outcomes and those are the three we care about even if
4 we could also show 200 other things it does. That is always the balance we are trying to
5 create, I think.

6 DR. LEMELLE: This is just a general comment. I appreciate what you
7 are going through. I think that there are so many different levels that this is happening in
8 other domains. With electronic medical records now, it is the same issue. Clinicians can
9 collect tons of information about an individual patient. They have a tendency to just
10 dump it all into the chart. Some of it is useful. Some of it is interesting. What are you
11 going to do with it is the bigger question.

12 We are having the same clinical struggles. How do you get people to
13 collect information that is actually pertinent to patient care and useful to that person, but
14 also useful on a broader scale to look at the functioning of a program? There are so many
15 parallels to what we are doing clinically.

16 DR. DELANY: I think one of things we're really working on is I work
17 very closely with Wes Clark around HIT issues. In addition to the evaluation, we are
18 trying to make things line up. It does make me crazy, but really it is an interesting
19 challenge for a researcher to think how do you make it line up along populations,
20 provider, individual outcomes?

21 This is the new learning for me is how do I work with the Centers to help
22 them think about those questions? What is going to be useful to drive the grant, but also
23 what is going to help sell our story, which is the other issue? We have a lot of good data

1 here. A lot of it can help sell a story, but how do we do it in a way that is efficient,
2 effective, but can also allow us to go external and show people outside?

3 That is a big issue because we talk about a lot of what we do is good, but
4 we haven't gone out and made our case as well. That is really kind of my driving force.
5 This data platform is useless if I can't use it to help Pam and Anna and Rich and Wes and
6 Fran go out and say what we do works, not just works, but does something really
7 impactful.

8 So the investment that we made was useful, do we want to go to scale with
9 that? NIH -- I have to tell you I can't tell you how many studies I ran around treatment
10 drug courts. It is kind of equivocal sometimes, but there are things about it that really
11 worked, but we never published the stuff that was really critical because the guys finished
12 and then they went on to the next study. We don't have that luxury.

13 We need to have data that really says it. We want to make sure that the
14 data we are giving the GPRA has really strong credibility. We have good data, but we
15 want to continue to improve that. The other thing that OMB is doing is they are down
16 our necks -- they are auditing us more and more. I can't tell you how many packages I
17 get every day that we do with our OMB officer where they have basically said that is
18 really cool, are you doing an evaluation? I was like, no, this is kind of the regular cycle.
19 They've said, well, if you are not doing an evaluation, then don't do that. How much do
20 you do?

21 That is why literally this whole data outcome and quality strategy is all
22 linked. This is one of the things that I link with everybody on some level. That is why
23 we are pushing so hard to get some commonality across what we are doing. That is going
24 to drive things. We are going to get these measures into the RFAs. We are also going to

1 make sure if there is an evaluation on top of just the data collection that that is the driving
2 force.

3 The one question I ask is the same one I ask my staff when they are doing
4 a research study, one of our short reports, which is so what. If we learn this, what are we
5 going to do with it? Sometimes it is just really interesting, but, quite frankly NSDA is so
6 big that I can do two correlations and get you a significant finding. It doesn't necessarily
7 mean anything.

8 DR. SPRINGGATE: Thanks for your presentation. You started off the
9 discussion or the presentation by referencing open.gov and the notion that there is a push
10 towards increased transparency and the opportunity to take advantage of the data that are
11 collected in new ways. I am wondering -- it is obvious that there are a lot of pressures
12 from different directions to figure out what is, A, the best data to collect at all and then
13 how should it be reported or not reported.

14 In a discussion with a colleague recently, who works at HHS, I learned
15 about efforts to take data that HHS is collecting routinely and make it available for
16 external application. I think she referenced an event coming up called Datapalooza or
17 something like that, recognizing that there is going to be -- which sounds perhaps
18 frivolous, but, in essence, I think the notion is there are lots of relevant, potentially
19 meaningful data that are collected routinely that only can be used in the moment for the
20 particular report that is being generated before someone has to move on to their next
21 report or their next project, leaving behind other critical, valuable, as you referenced,
22 information that may or may not have an opportunity for application.

23 Given lots of interests out there in this sector, who would like to be able to
24 take advantage of that type of data for the public good, I am wondering if you see it as

1 part of your strategy. Is there an opportunity to find ways to really take advantage of
2 those external, data-hungry stakeholders, whether it is through a datapalooza-type effort
3 or otherwise to better take advantage of and make even more use, cost-effective use, of
4 the data that you are working on?

5 DR. DELANY: Yes. That is something that we're thinking about not in
6 parallel, but at the same time. Again, this is one of the real conundrums. Some of this
7 data -- you can take two pieces of software and you can actually figure out who the
8 person is. We need to be able to generate this in a way -- there are ways to de-identify
9 things. That is something we have to do.

10 Obviously, things that will come up will be probably when we get the
11 public interface up, for example, just take PPW, the Pregnant Post-partum Women
12 program just because it was on my mind today because I was reading something.
13 Obviously, when we put that up on a public site it would only be in general. It would be
14 just totally aggregated. You would not break it down by program.

15 There might be opportunities later for researchers to use it similar to what
16 we do with our restricted data, to sign up, go through training, and sign certificates of
17 confidentiality. Then we can limit how they report out. We don't want them to report
18 out by grantee, unless the grantee has a lot of people or a lot of programs. We might say
19 you can report out by grant program and things like that.

20 We actually have a parallel process going on right now where we are
21 creating data portals, restricted data portals for NSDA and for DAWN, which, as you
22 know, is being revised, resubmitted, and coming out new. I am now the new MC for the
23 agency.

1 DR. SPRINGGATE: I guess I'm thinking, you know, maybe more along
2 the lines of information -- you have to jump through obviously a lot of hoops to be able
3 as an external partner or an external user of information to use identifier-linked
4 information, but de-identified data, by contrast, may be relevant to a wide array of even
5 people creating little applications on iPhones and things like that.

6 MS. HYDE: Martha's actually involved on some levels with some of the
7 folks, who are trying to get to the liberating the data issue. Neil Russell, in Pete's shop, is
8 also trying to work on that. We are conscious of that and trying to figure out better ways
9 to make that happen.

10 DR. ENOMOTO: We've already got the treatment locator data connected
11 with some app developers, who have integrated that with -- what is it called? -- iTriage.
12 We have the more administrative type of data already connected with the open.gov and
13 the Challenge and the Datapalooza stuff. We have been participating. I think the trick of
14 de-identifying the services type of data, we are some ways away from that.

15 DR. DELANY: The other thing is we can create public use files for a lot
16 of this, which allows people to do an awful lot without even going through the -- even the
17 de-identifying is a little tricky, but we are looking at that. Also, part of the evaluation
18 process, is how do we warehouse the evaluation information so that people can go
19 replicate it? It is good enough that we did an evaluation that came out and said yay or not
20 so good, but it would be nice if other people took it and played with it or asked questions
21 we didn't think to ask.

22 Our job as a Center is really to put as much information into the hands of
23 people as possible, but also do it in a way that when they are looking at it there is enough
24 understanding of the caveats. You can't just throw data out because we have seen what

1 people do with that, but they need to understand that. The other thing is once they get it
2 out one person sees it and says no and three other people say wait a minute, let me ask
3 that question a different way.

4 The whole process is sweeping along. It is kind of fun. Scary as heck,
5 though. Every time I think I have it nailed, I have to tell you that Pam and Kana say did
6 you think about this. I say nope. I go nope a lot.

7 DR. MARSH: I just wanted to mention another use that we have for these
8 performance data from the discretionary grants. CSAT started this and CMHS emulated
9 the model. It is for the purpose of oversight of individual grants and their performance.
10 CSAT established what they call a Continuation Board. At the point in the year that the
11 continuation applications are coming in for the discretionary grants, they have a board.

12 We now have a board, similarly, who take a look at the data from these
13 systems. What were the numerical targets that the grantees set? Are they meeting the
14 targets? Are they falling way short? Are they not submitting any data? This really has
15 enabled us to take a more systematic look and consistent look at the performance of the
16 grantees so that we can identify grantees that are really struggling and need some
17 assistance. We have found that extremely useful.

18 DR. DELANY: And that'll be a key functionality issue.

19 DR. KOPANON: I just wanted to mention that this has forced us to look
20 at a lot of our programs in terms of what are the goals and objectives of the program?
21 You could take a program like the one Pete mentioned, pregnant post-partum women, in
22 all of our treatment programs in CSAT, the outcome of treatment is really the core of the
23 program. We need to look at treatment outcomes and anything attendant to that.

1 For example, in PPW, people ask, well, what happens to the children? In
2 our HIV/Aids program, it is what HIV status, what are the result of your rapid testing? In
3 drug courts, it is other questions. Each program has not only the core issue, but an
4 attendant other range of issues and data that could be collected that would be of us and
5 we do get asked about. On the one hand, we do need to focus and narrow down to the
6 core issues and the core aspects of the program, but also there is this constellation of
7 other kinds of thing that may or may not be similar to the health records. What other
8 kind of information would you put into a health record that maybe if it is electronically
9 transmitted to a different physician would be of interest to them.

10 DR. WONG: I wish Hortensia was here because there is this other aspect
11 of SAMHSA, which is so unique, looking at community and how it impacts the
12 community as a whole, however you define that community -- I am thinking about
13 schools. I am not sure that we have those measures yet when we implement, for instance,
14 preventive aspects of our grant and how do you then measure outcomes and impact on
15 sort of pre and post- this intervention or this program. That is something that I would be
16 very interested in seeing if you had any ideas about how to do that.

17 MS. HYDE: Actually, this again may be a 30,000 foot comment about
18 that, but we actually struggle with -- we have state level data at a population base. We
19 don't have community level data that is consistent across the country. We don't even
20 have a consistent definition of community for doing that data.

21 We have run into that recently where we wanted to make some decisions
22 about high need communities and it was difficult to do sitting here. Each community or
23 maybe even each state can make a determination about what is high need on the basis of
24 something or another. People argue about whether or not a high-need state also is

1 reflective of high-need communities or whether there can be a high-need community in a
2 low-need state? There is lots of -- it is just overwhelming on some levels.

3 Then when we define community differently -- in one place, we define it
4 as a two block area and in another place we define it as a community in another place we
5 define it as a school, which, of course, people can come to schools from different places.
6 It starts getting even more complicated. That is also something we have been struggling
7 with.

8 DR. DELANY: It is something that we are spending a lot of time on. My
9 staff is interacting pretty heavily with CSAT on a lot of these issues. I think we are
10 making some good progress.

11 DR. HARDING: I think Pam actually covered it. It is a combination of
12 everything Pam said and the difference between process and outcome. When you are
13 talking about what we call an environmental prevention strategy, you are talking about an
14 effect over an entire community versus a preventive strategy in which you are looking at
15 a person's development.

16 When you are asking for state data, then we also need the community data.
17 How do the two interact? It is just as Pam was saying. Pete has become our -- I would
18 say a member of the Center because we see him so often. He will actually be working
19 out of three Centers now. It is very important -- we collect so much data. Similarly to
20 what Rich was saying, what data do we really need to tell the story?

21 We don't define community because we allow the science to define it for
22 us. That is a problem. We are in the middle of trying to figure all of this out. The
23 problem we have is that we want this done tomorrow. You saw the timeline is 2014. We
24 are having some difficulty finding some shorter measures.

1 DR. ENOMOTO: You can imagine some of the challenges. We need
2 telescoping data. We need data that can tell us how is this grantee doing? How is this
3 grant program doing? How is ATR doing? We have been asked that question many
4 times. Then stepping back, how is CSAT doing? And then someone will ask how is
5 SAMHSA doing? Does SAMHSA make a difference? Does SAMHSA make a
6 difference for women? Does SAMHSA make a difference for communities? For
7 children?

8 We are going to try to get some standardized data elements coming out so
9 that we can answer that question across SAMHSA. CSAT has been, I think, leading on
10 this for us, largely because their programs are very services oriented. I can ask how is
11 CSAT doing for individuals who are homeless and they can say here are the homeless
12 people in our homeless grant programs, but here are also the people who report being
13 homeless at the beginning of their treatment in all of our other programs, which is very
14 useful sometimes, but then being able to do that across Centers.

15 For those of you who have been grantees from multiple Centers, you will
16 see that the work that the -- the grants that come out of CSAP are state and community-
17 oriented. They are about environmental prevention strategies and community-level
18 outcomes, more than individual and family-level outcomes. In CMHS, there are some
19 programs with individual and family-level outcomes, but also many which are
20 infrastructure oriented.

21 The challenge that our staff has taken on is really formidable in coming up
22 with a common data platform, which can address all of those things. It would be hard
23 enough just to do it sort of like combining EHRs or clinical records if we were just doing
24 services grants, but we are doing much more than just services grants. Even within our

1 services grants, some are very short term, what we do with crisis counseling versus what
2 you do in systems of care where you see a kid for a very long time.

3 It is really a tremendous intellectual and technological evaluation
4 challenge. I want to give credit to Owen, who has taken this on, Pete, who has really
5 bravely and good naturedly, both of you, taken on this task, and our Centers and their
6 staff, who have -- it hasn't been an easy process, but I think everyone is putting such an
7 incredible effort forward to try to work together, to try to achieve this goal, which is very
8 hard. When you have different needs and different goals, slightly, with your programs, to
9 sort of give that up and trust that somehow your needs and your goals are still going to be
10 met by a system that is kind of controlled by somebody else and designed by somebody
11 else is really very difficult.

12 I think our team is coming together and putting forward a good effort. I
13 think the MITRE folks have helped. I appreciate people bearing with us as we have
14 introduced that new element. I think we will have a good product at the end.

15 DR. ROTH: On your slide that's called CDP: Progress, you talked about
16 collaboration with stakeholders and the Centers are listed. Clearly, the Centers are your
17 stakeholders in this, but I am wondering what the connection has been with people in the
18 field. Where I am going with that is the data are actually going to end up being collected
19 out there god knows how or how angrily. I know this well.

20 DR. DELANY: I have actually learned about that more recently.

21 DR. ROTH: As far as what the measures are and how things get collected
22 and what has the connection been or is that coming?

23 DR. DELANY: I think that is one of the next phases. First, we have to
24 figure out what this animal is going to kind of look like. We at least need something --

1 essentially, we have to think what are our common elements and what are our unique
2 elements going to look like and then go out and engage a little bit about that.

3 I have learned that if we have a meeting, then everybody's measure
4 counts. I have had a couple of meetings just on some other things related to this. What I
5 thought would be a really easy process to kind of come to consensus turned out that
6 everybody had 13 different measures they wanted. We need a product to show them and
7 to get them started and then I guarantee you that everyone is going to say that is great, but
8 let's add these five or six or seven measures. It is just going to be a winnowing process.

9 At some point, I am going to walk up to Pam and say I think we are at the
10 point where we just have to start with it and move. This product, really -- what Rick was
11 saying about GPRA is we actually have to be able to prove what our investments are.
12 That is kind of an internal process to some degree and then there is going to be teaching
13 people over time because there is going to be some TA laid out.

14 The other thing is as we kind of come to an agreement and get to a
15 consensus about the measures we actually need to run the program, as we slim this down,
16 which will hopefully lead to a slimmed down GPRA, then I think the field, actually -- at
17 least what I am hearing from people in the field because I have had some minimal talks
18 about this is, you know, if you get this so it is easy for us, we can get the information to
19 you because as things move and change that is our problem.

20 It is a moving target sometimes. If we can come up and we can stay stable
21 -- I have commitments from Pam and Kana that they are going to stay behind this
22 because Congress -- that is part of the problem -- Congress said we told you to do this,
23 but actually we wanted to know about this issue.

1 We are going to come up with a business rationale saying this is why we
2 are doing it this way and we are going to focus on this. As long as we are saying that is a
3 really important point and it kind of relates -- it is kind of like a statistical anomaly,
4 which was the topic yesterday -- as long as it is statistically connected we should do it,
5 but we need to said might be interesting, might be useful, but it is not going to help us
6 judge the program.

7 DR. ROTH: I realize that you have the dilemma when you go out into the
8 field of presenting something that is cogent and coherent enough that they don't say
9 what, did you not think about this yet? On the other hand, I guess I would caution you a
10 list of defined and determined measures and how those data get collected. It is not so
11 much that you are going to hear you want six other things. You are going to hear that it
12 can't get collected like that. That is not how they do it in the field. That is not how we
13 count things. We don't have a system set up for that.

14 MS. HYDE: If you haven't figured out, Dee has a lot of experience in
15 trying to put these systems together and taking all of the slings and arrows from the
16 people that don't want to do it. She is on the Council now because we knew that we
17 needed that kind of perspective. Thank you, Dee. Keep asking the question and keep
18 pushing and maybe you and Pete can continue some conversations offline as well.

19 I just want to let you know that Arturo is on the phone. Hello, Arturo.

20 DR. GONZALES: Hello, Pam. I am sorry, but I just got your message
21 now that you needed me for a quorum.

22 MS. HYDE: Yes. We got the quorum. Thank you. Can you stay with us
23 for a bit?

1 DR. GONZALES: I sure can. It is a two hour difference. You forgot
2 about that.

3 MS. HYDE: Yes. We knew we were going to make you get up early.
4 Nobody has it over the Pacific jurisdiction at this point.

5 DR. GONZALES: How do you know I'm up.

6 MS. HYDE: Yes. Great. Thank you. We will come back to you, Arturo.
7 I will let you get awake and get some coffee.

8 DR. GONZALES: Oh, I'm fine. Thank you.

9 DR. STEIN: This conversation is so important. I think we need more
10 conversation and maybe some tools for the part that you talked about about transparency.
11 We have an open window. Every contract, every grant we do has to be published on the
12 web for everybody to look at.

13 Right before we went live about 30 days ago, we said everybody look at
14 your measures. Are you sure you want to defend your program with these measures that
15 we all thought were wonderful all along until you put them out like that for every
16 member of the legislature, every member of the public, consumers, and competitors to
17 look at and see this is what you are asking for?

18 We weren't so sure. We had to go back and really take a look and then
19 see if we could actually measure and collect data on the things that we thought the public
20 would really ask us for. It was a really big conversion to go totally transparent.

21 MS. HYDE: I think that point is extremely well taken, Flo. The person
22 who is the head of AHRQ, my colleague, I have often heard her say there is a stakeholder
23 group for every measure. I think this issue of what you limit any data system to -- it
24 doesn't matter whether it is our National Quality Framework or whether it is the common

1 data platform or what we are going to do with the block grants, whatever it is -- there are
2 going to be people who argue that those are not the right things to collect or we should
3 collect other thing.

4 I actually just have to keep bringing myself back to in the end is it making
5 a difference? On some levels, we like to collect data about evidence-based practices so
6 fidelity issues to that. We like to collect information about how many people do we
7 serve. I have been on a bugaboo lately, which some of the staff know about, that we sort
8 of get into this issue of how much does this stuff cost per person.

9 Unless we have some evidence that costing that much is getting us the
10 right outcome, I don't really care. I don't know whether costing less per person is a good
11 idea or maybe we should be costing more per person in order to get the outcome. We are
12 actually trying to start to ask can we get the cost per outcome. If I serve 1,000 people,
13 but only 100 of them get better or get to the point we want them to get, let's do the cost
14 per the 100, not the cost per the 1,000. You can serve 100,000 people and if you don't
15 get any outcome from that, if you don't get employment, if you don't get a job, if you
16 don't get a life, if you don't get recovery -- whatever the issue we are trying to get --

17 DR. STEIN: That is the question for managed health care.

18 MS. HYDE: It is.

19 DR. STEIN: They don't care about all of those other things anyway.
20 They want to know the cost per the outcome that they were looking for.

21 MS. HYDE: It is really hard. I think there is something fundamental
22 about quality of care is not necessarily the same thing as an outcome. You would think
23 that higher quality care would get you better outcomes. We can argue that. Most of the
24 time it should, but there is a little bit of argument there. We do need to understand what

1 quality services are and quality care. We have a tendency to focus on how many people
2 did we serve or touch and did we get some kind of quality in that, however we define
3 that.

4 We spend, unfortunately, less time talking about what did it result in, in
5 terms of real outcomes either for individual people or for communities, which is the
6 struggle, or larger for populations. We can show -- this is kind of the flashlight analogy.
7 We can show lots of good outcomes. The prevention data is great about this. If you are
8 doing a prevention program in that community at that time, you can show some real
9 reductions in teen alcohol use in that school for that period of time or whatever we can
10 show.

11 Unfortunately, when we stop giving them the money, we also stop getting
12 the data. Sometimes we don't always know -- did it continue after we quit or not? What
13 we can also then tell you is that the deaths from teenage drinking is the same as it has
14 been for several years so we are not making a difference in that. What do we need to do
15 differently to get that 5,000 number down? Pick something else.

16 Staying focused on are we making that difference, especially from a
17 federal level -- is everything we are doing collectively getting the population numbers to
18 go in the direction we want them to go? If not, then the real struggle is then what would
19 make a difference? Just more flashlights? Arguably, if you have 100,000 flashlights,
20 you are going to have a bright light. 100,000 flashlights that keep moving around, is that
21 -- there are lots of conversations that come from that.

22 These are interesting policy discussions even though it is a very technical
23 how do we do the data platform and the contract kind of thing. The next time Pete tells

1 me it takes three years to get another data element into the population survey -- we keep
2 going around and around about that.

3 DR. DELANY: I'm never going to say that again. Dee said it was right.
4 She is my best friend now.

5 MS. HYDE: Dee taught me a lot about what I ask you, Pete?

6 DR. DELANY: A lot of this is -- not only do we have to have the
7 functionality that the Centers need to be able to do their job and report up to Congress
8 and make them happy, but we do have to be able to collect the data. Let's be honest.
9 They have made a lot of changes already. They are not going to be happy as we ask them
10 to make more changes.

11 We have to actually -- when we get out there it is not only can they collect
12 it, but is it the right -- we are going to have to have disagreements and the ability to
13 evolve. That is the other thing about this system is it has to be able to evolve over time.

14 One of the other overlays is that we have a new program called the
15 Community Early Warning and Monitoring System, which came out of something that
16 ONDCP pushed, which is really a community indicator. I am going to be working with
17 Fran over the next six months to get it ready to go to whatever level we are going to go
18 next year depending on the budget. We will be working to kind of identify what are
19 those six or eight indicators that actually can help us say this is what we need to know
20 and we can collect regularly -- okay five indicators, I don't know.

21 DR. STEIN: How are we gonna know ahead of time so that we can tell
22 everybody something is going to happen?

23 DR. DELANY: We will be having a number of expert panels and things
24 of that sort. The other question is how do I align this with the quality strategy, the

1 evaluation strategy -- this is for me. I need to be paid better. No. A lot of this is -- she
2 will tell me I talk too much. It is okay. I am used to it.

3 All of these things have to align in a way and they have to make sense. It
4 is a tremendous thing. Again, the Center staff, especially the staff that they have been
5 targeting to work with us directly, have been really great in helping us to think through
6 the things that we, as data geeks, really don't get.

7 When I put on my clinical hat some of that makes sense, but when I am up
8 in the Center I am trying to figure out how do I make this all drive. It has been a
9 partnership. It is getting better. We are really looking forward to keeping that. As I start
10 having some of these external panels with experts, we are looking for that to drive it.

11 MS. HYDE: See for the next six months, he'll be dealing with all of those
12 grants and all of those people who are concerned about changing things so he will get that
13 perspective as well.

14 You said something that I just want to highlight. One of the things that I
15 think we have learned in this process is that some of these contracts or some of these
16 efforts that do the datasets that we are trying to pull together do other things as well.
17 They also help grantees collect data or they help provide technical assistance to people to
18 know how to give us the data. We also have learned that.

19 There is a set of activities going on that we are trying to figure out where
20 is that going to land. Is that going to land in the same place? Is it going to stay in the
21 Centers? Is it going to stay in different mechanisms? Those things are rising as well.

22 Any other comments about this? You guys want to make any further
23 comments about this? I think the Centers have really been very vocal and appropriately

1 so about don't make these changes without really thinking this through. I appreciate the
2 work that they have been doing on it.

3 From the perspective of a grantee, from the perspective of a data and
4 evaluation person, from the perspective of clinical people and state commissioners and all
5 of your perspectives about this would be really helpful. If this stimulates more for you,
6 please shoot us an email. I think in this case it would be perfectly appropriate to send it
7 directly to Pete. He is Peter.Delany@SAMHSA.HHS.gov.

8 Larke, come on forward. While you are coming forward, Ben just shared
9 with me some materials. I thought I would give him a chance to talk about. Do you want
10 to talk about this?

11 DR. SPRINGGATE: Thanks, Pam. During the break, I took advantage of
12 the opportunity to share with Pam a recent special issue of Ethnicity and Disease that
13 came out a couple months ago that was put together through the partnered research center
14 at UCLA and Rand, addressing community-partnered approaches to address disasters and
15 disparities in mental health.

16 A number of efforts from across the country are highlighted in the context
17 of the special issue. A number of community partners, who have been involved in
18 implementation of work in places across the country as well as academic partners, are
19 represented in those pages with an emphasis on things like the school-based work that
20 Marleen Wong and Sheryl Kataoka has been leading in Los Angeles, work that Margarita
21 Alegria and her partners have been leading in Boston, that Genie Miranda and her
22 partners have been leading in Los Angeles, a number of our partners in the greater New
23 Orleans and Gulf States area have led after disasters, in terms of training and
24 implementation programs for victims of disasters.

1 I appreciate the opportunity to share a little bit about this. We are hopeful
2 that some of this work, demonstrating some of the practical relevance that “research
3 opportunities” done in partnership can have on the ground for people in communities
4 with community members deciding what is the research that needs to be done and helping
5 to implement it and helping to determine what the data means. It may provide further
6 opportunities for progress moving forward. Thank you for letting me share.

7 MS. HYDE: Thanks, Ben. I appreciate it. Later, Stephanie is going to
8 tell us some stuff, but we will wait for that.

9

10 ***Agenda Item: Behavioral Health Disparities***

11 MS. HYDE: I have already told these folks that it is LGBT health
12 awareness week. You have materials in front of you that you are going to hear a little bit
13 about. I am going to turn this over to Larke. I will let you start. You can introduce Alex
14 and Ed. We will go from there.

15 DR. HUANG: Great. Good morning. Thanks for letting us do this
16 presentation on some of our LGBT issues going on in SAMHSA. You have the
17 PowerPoint and you also have, I think, this organizational flow chart, which is kind of
18 our acting chart of how we function around some of the behavioral health disparities
19 issues at SAMHSA.

20 I direct the Office of Behavioral Health Equity. Within that, we have a
21 number of different special population focus groups, including our Sexual Gender
22 Minority Interest Group, which focuses on lesbian, gay, bisexual, and transgender
23 behavioral health issues.

1 We approach these issues with two thrusts. One, we want to look at how
2 do we integrate our focus on the LGBT population within existing SAMHSA policies,
3 programs, procedures, and mechanisms. The second piece is more of a pull out piece.
4 How do we focus attention on these particular population groups with special projects,
5 with special initiatives, and other kinds of activities?

6 The functions of the workgroup are doing some of our departmental and
7 interagency work, doing some of our stakeholder outreach work, doing the policy work in
8 the sense of, for example, in each of the strategic initiatives, there are specific action
9 items that will focus on this population group. We have significant data activities going
10 on as well as training, education, awareness, and some material development. Those are
11 the areas in which this particular workgroup functions and does their activities.

12 We have a workgroup, here, comprised of staff across the four Centers and
13 the Offices. The workgroup is co-led by three staff, one from each of the programmatic
14 centers. They are Ed Craft, who is from CSAT and he is going to start the presentation --
15 he is up at the podium --, Alex Camacho, who is from the Center for Substance Abuse
16 Prevention, and then Michelle Carnes, who unfortunately couldn't be with us this
17 morning. She is the co-lead from the Center for Mental Health Services.

18 I am going to turn it over to Ed and Alex, who are going to take you
19 through the presentation and some of the work of our SGMIG group here at SAMHSA.

20 DR. CRAFT: Thank you, Larke. Can everybody hear me through this
21 walk around mic? Larke has gone over these two slides. In the briefing today, we are
22 going to talk about Selected Federal Policy Initiatives and Interagency Workgroups,
23 SAMHSA's initiatives, the SAMHSA Sexual and Gender Minority Interest Group, and
24 data and measurement initiatives.

1 First, we will talk a little bit about policy initiatives and interagency
2 workgroups. The primary interagency workgroup that we collaborate with is the HHS
3 LGBT Coordinating Committee. It includes representatives from all staff, offices, and
4 operating divisions across the Department. It is Chaired by Dr. Howard Koh, the
5 Assistant Secretary for Health, Kathy Greenlee, who is the Assistant Secretary for Aging,
6 and Ken Choe, who is the Deputy General Counsel. Pam is also very, very involved and
7 doing a lot of good work on this project.

8 What happens on the HHS LGBT Coordinating Committee? Of course,
9 we coordinate LGBT activities across the Department. One of the things that we are
10 doing is we have done some regional listening sessions and the Department has done
11 some regional listening sessions across the country, which the Secretary developed into
12 report, which is on the website.

13 We have also are in progress with regional conferences that our new
14 regional administrators are involved in. The first one was on LGBT health in
15 Philadelphia. Several of us had an opportunity to participate in that. I presented a
16 workshop on substance abuse and mental health. The second one was on housing and
17 homelessness. The third one is going to be on HIV/AIDS. That is upcoming.

18 We have -- when the Secretary transmitted the hospital visitation
19 regulations to the Secretary, he asked her in that transmittal, to let him know what other
20 issues LGBT individuals and their families have. That initiated a process at HHS where,
21 starting in 2011, each Operating Division and Staff Office is asked to develop proposals
22 that they will implement over the coming year.

23 SAMHSA's proposals for 2012 include developing best practice
24 guidelines to prevent and reduce family rejection of youth who are LGBT and their

1 associated problems, such as homelessness, behavioral health disorders, risky sexual
2 behaviors, and suicide. Another is to integrate a stronger component on LGBTQ youth in
3 all HHS anti-bullying campaigns.

4 The third one is to implement a joint framework with HRSA to inventory
5 existing LGBT2-S -- the 2-S is two spirited for those of you who may not be aware of
6 that -- cultural competency curriculum within and outside of HHS and to share existing
7 tools with safety net providers and highlight training efforts that integrate behavioral
8 health in primary care. SAMHSA and HRSA will create a plan to disseminate existing
9 tools to diverse practitioners to assess, treat, and refer LGBTQ clients in a culturally
10 competent manner.

11 Our fourth proposal is an ongoing one. That is our continued support and
12 field testing of standardized items for LGBT populations in the CDC National Health
13 Interview Survey. Alex is going to talk about that a little later. Our final proposal for
14 2012 has to do with implementing a policy that will identify existing LGBT evidence-
15 based practices and help to create new ones that we can identify.

16 We have a reporting process for the HHS LGBT Coordinating Committee.
17 We do monthly reports, which are rolled into an annual report. All of the Operating Staff
18 Offices put that together. It is rolled into an annual report for the Secretary. The 2011
19 report will be issued by the Secretary and will be on the website, we hope, sometime in
20 April.

21 We know that health reform is going to help ensure access to health care
22 for LGBT individuals. There are a number of ways that that will happen because we
23 know that providers and Medicaid are going to have to include all populations without a
24 co-pay and have a focus more on behavioral health as a part of integrated health, a greater

1 inclusion of prevention and wellness, and, finally, in addressing LGBT populations,
2 section 4302 of the Affordable Care Act, which talks about data collection -- Alex will
3 talk about it later -- there is a focus on including LGBT populations in those data
4 collection efforts.

5 The Centers for Medicaid and Medicare are also implementing a
6 regulation on long-term care benefits and asset protections for senior LGBT citizens so
7 that their partners and loved ones will not lose the assets when another partner goes into
8 long-term care.

9 What has the Office of the Secretary done for LGBT issues? Well, there
10 have been issued internal policies ensuring that LGBT individuals have equal access to
11 HHS programs and employment opportunities. They also established the Healthy People
12 2020 LGBT Workgroup, which will help guide the development of measures to identify
13 LGBT health needs and progress in addressing them.

14 Here are some of the accomplishments, very quickly, by some of the other
15 operating divisions of SAMHSA. The Administration for Children and Families has
16 created a resource center to support resettlement of LGBT refugees. They have also
17 funded the Los Angeles Gay and Lesbian Center to address barriers to permanency and
18 well-being for foster children.

19 HRSA, the Health Resources and Services Administration, has funded a
20 national training and technical assistance center to help community health centers provide
21 more culturally competent care for LGBT clients. That grant is housed at the Fenway
22 Health Clinic in Boston.

23 NIH funded the report The Health of Lesbian, Gay, Bisexual, and
24 Transgender People: Building a Foundation for Better Understanding. The overarching

1 recommendation that came out of that report was to develop a LGBT research agenda
2 that includes demographic research, social influences, healthcare inequities, intervention
3 research, and transgender-specific health needs.

4 Here are some selected SAMHSA LGBT initiatives. Relative to RFAs
5 and contracts, we had put in our service template's language that we will permit LGBT
6 populations to be included where appropriate, either as a target population, one of many,
7 or even a singular target population. We are also incorporating a focus on LGBT
8 populations in our strategic initiatives. We have 36 action steps across the eight strategic
9 initiatives.

10 Some of the programs that we are focusing on this year include suicide
11 prevention, helping to eliminate youth tobacco use, to preserve and expand the suicide
12 helpline, and integrate a component of LGBT youth in the anti-bullying campaigns and
13 efforts.

14 We have a number of training and cultural competency efforts going on at
15 this time. As I said earlier, we are working with HRSA to develop an inventory. I meant
16 to bring a copy, but I am sure most of you are aware of the publication of Provider's
17 Introduction to Substance Abuse Treatment for LGBT Individuals. It is now in its fifth
18 printing. It is one of the most popular books to come out of the SAMHSA
19 Clearinghouse.

20 We have developed a training curriculum that goes with that, which was
21 actually developed by the SAMHSA-funded Prairielands Addiction Technology Transfer
22 Center. That curriculum has 22 components. It has been delivered a couple hundred
23 times across the country. Four states have actually implemented it -- the State Director
24 has actually implemented it through its provider network. It is quite a long curriculum --

1 it can take over 20 hours --, but it is a very adaptable curriculum. You can put together a
2 combination of whatever modules best meet your needs.

3 Alex is going to speak about data efforts so I will leave that one alone.

4 Here are some of our other efforts. The Strategic Initiative number one, of
5 course, as we know, is prevention of substance abuse and mental illness. The Garrett Lee
6 Smith Suicide Prevention Grants are for state and tribal suicide prevention. There were
7 38 new grants awarded in this last cycle. Of those 38 grants, ten are focusing on LGBT
8 youth by doing outreach, developing a webpage, a Facebook page, and adapting best
9 practices to be culturally relevant for LGBT.

10 We have a new program, Twelve Cities, which is helping to integrate
11 substance abuse services and other behavior and mental health services as well and Aids
12 care in cities with the largest number of Aids cases. This is a cross-SAMHSA initiative
13 where we have government project officers and other people working on these programs
14 in CMHS, in CSAT, as well as CSAP.

15 The National Workgroup to Address Needs of Children and Youth who
16 are LGBTQI and their Families in systems of care continue to meet regularly. They
17 identify specific strategies and interventions that address the needs of these individuals
18 and their families through the context of a public health model.

19 As I mentioned before, there has been quite a bit of collaboration between
20 HHS, the Department of Education, and SAMHSA to work on bullying issues. One of
21 the things that we have been quite involved with is the website stopbullying.gov, which
22 has a new LGBTQ youth section, which SAMHSA has been instrumental in providing
23 input to.

1 Under strategic initiative number four, which is recovery support, we have
2 the Communities of Practice on LGBT Issues. That group is funded by the Suicide
3 Prevention Resource Center. Over the next four years, 28 current and alumni grants of
4 the Garrett Lee Smith Grant program will develop specific LGBT youth projects and will
5 come together to share resources with each other and pool information.

6 As I mentioned before, one of our proposals for this year is to compile
7 LGBT cultural competency inventory with HRSA to figure out what the gaps are, figure
8 out what pieces we can combine, and how we can push it out to providers and other
9 stakeholders.

10 As I mentioned before, we are developing training programs and other
11 events. We are also working with our partners, HRSA, AHRQ, and other Op-Divs, to
12 develop an LGBT Pride Month Program, a history month program, a National LGBT
13 Health Awareness Week. We will have a program here next Monday with a panel of
14 speakers to help educate our staff on LGBT behavioral health issues and how they can
15 incorporate that into providing guidance to their grantees, their contractors, and other
16 stakeholders.

17 Last year, we did our Pride Month program with HRSA. It was very, very
18 well attended. We were very fortunate to have John Berry, the Director of the Office of
19 Personnel Management, as well as Dr. Frank Kameny, who is a federal pioneers, who
20 was the first person to speak up in 1957 as a federal employee who was fired solely for
21 being gay and said I am not going to take it anymore. He spent the next 50 years, 50 plus
22 years advocating for federal employees with issues related to their sexual and gender
23 orientation. Dr. Kameny passed away about three months after he spoke with us. It is on

1 YouTube, not the SAMHSA website, but there is a video of Dr. Kameny's presentation
2 and I would encourage you to view it when you have time.

3 We have had a number of webinars on understanding health disparities
4 across the Department. Under strategic initiative number eight, which, of course, is
5 communication, we have a new product, which Alex is going to talk about in more detail,
6 the Top Health Issues for LGBT Populations Resource Kit. We are also, here, at
7 SAMHSA, developing Sharepoint site so that we can integrate all of our LGBT materials
8 so that we not only have them for internal use, but that we are able to share information
9 with the public about what we are doing and what we know.

10 This is the Top Health Issues for LGBT Population Information and
11 Resource Kit. I am sure Alex will come back to that.

12 Some of the other activities that we include - the National Action Alliance
13 for Suicide Prevention Taskforce on LGBT Suicide. We also have the Advancing
14 Recovery Opportunities for LGBT Individuals, which was a program that CMHS put on
15 last summer where they brought in people from around the country -- consumers,
16 providers, a very diverse group -- to look at what are some of the behavioral health needs
17 for LGBT populations. It was a two day meeting. All of the input from stakeholders was
18 recorded. There is a monograph that is currently being developed. It is about to go into
19 content plans.

20 Last fall, we had a HRSA/SAMHSA listening session with about 30
21 representatives of national organizations, community-based providers, and others from
22 across the country. They came in. We asked them some strategic questions. They
23 provided information. A lot of this had to do with and around training of providers to be
24 LGBT healthcare competent.

1 I think you are up.

2 DR. CAMACHO: Hello, everyone. I am Alex Camacho. I am going to
3 go back to my prevention roots and just have a conversation with the NAC, if that is
4 okay. I won't go slide by slide because I just roll like that. It is really, really awesome to
5 be here. I can't even explain how awesome it is. I just want to have a conversation about
6 a population that is a focus of SGMIG and also of SAMHSA.

7 I want to highlight some successes and what we do internally and what are
8 some of the hot issues that you should all be aware of. At the very end, being the
9 preventive person that I am, I have a couple of questions for you guys. Hopefully, you
10 guys get to learn from us as well as we get to learn from you in terms of where should we
11 go. I am an army vet so I believe in sound bites. I will try to be very brief and allow
12 time for some discussion.

13 SAMHSA has SGMIG, which is a workgroup we co-lead. We have three
14 committees. One focuses on administration and policy, led by Michelle Carnes. That
15 really looks at what we are doing internally through grants and contracts as well as
16 employee benefits.

17 We have the Cultural Competence Committee led by Ed Craft, which
18 focuses on how can we get our workforce trained on LGBT health issues because this is a
19 vulnerable population, probably more than most, because we don't know much about it.
20 If you have had the pleasure of reading the recent IOM report, their opening statement
21 says lesbian, gay, bisexual, and transgender individuals have unique health experiences
22 and needs, but as a nation we do not know what these are. That, I think, is very clear
23 about the lack of data we have at a national level regarding these vulnerable populations.

1 Then there is the Data Committee. I am a scientist. I lead that one. I love
2 data. I work with Pete and his shop very, very closely to look at how can we strengthen
3 our data collection efforts around this and how can we advice the Department. I am very,
4 very proud -- we are all very proud of the fact that SAMHSA has been invited to the table
5 multiple times by ASPE, the OASH, to advice the Department on where we should go
6 with data collection efforts, what have our successes been, our challenges, and how can
7 the Department capitalize on that.

8 Yesterday, we had a national conference call with Dr. Mary Wakefield,
9 Administrator of HRSA, GLAMA, Gay and Lesbian American Medical Association, and
10 the National Coalition. We talked about our own successes at SAMHSA and the release
11 of our kit that I will talk about in a minute. That was very, very important because these
12 are stakeholders dealing with these populations. They are look to us for leadership and
13 we are using our experiences and our data to help inform that kind of discussion at a
14 national level. I thought that was very cool because we were right there at the table.

15 Let's talk about some of the hot issues that we have. First and foremost,
16 you have a copy of this kit, which is developed by the Centers for Substance Abuse
17 Prevention. The audience for the kit is really prevention specialists and health care
18 providers. Why? Because when a person enters treatment -- I am a clinician as well --
19 when a person enters treatment, providers need to know, first, the terminology they
20 should be using or should be aware of, some of the health issues, both physical health,
21 behavioral health, and sexual health that are common among these populations.

22 Prevention specialists are key because if we want to increase the
23 awareness among providers as well as the public about why investing in these types of

1 services, specific to LGBT population, then they are instrumental in creating that
2 awareness across the country and among their own constituencies and stakeholders.

3 This was a great success. We had 53 peer reviewers across the
4 Department. We got Departmental clearance in seven working days, which I think is a
5 testament to the support of the Office of the Secretary. We will be continuing to promote
6 this kit and lead the way in terms of these efforts.

7 I wanted to update you on some data, measurement, and initiatives that are
8 going on across the Department because we play a key role. Right now, we have an
9 interagency agreement with the National Center for Health Statistics to field test and
10 validate a population level measure of sexual identity. I just want to clarify that sexual
11 orientation is a composite measure. We need to measure identity, attraction, and
12 behavior.

13 Right now, we are leading the way with identify. This is going to be
14 critical because this will be included in the National Health Interview Survey as of 2013.
15 As of 2015, it will be included in our own NSDA so that we can further the
16 understanding, at a population level, about the behavioral health needs of the LGBT
17 populations. Does that make sense to everyone? Good.

18 Right now, there are initial discussions at the Department around gender
19 identity. We know that transgender populations are independent of sexual orientation.
20 Gender identity is a different kind of measure. The Secretary is going to put forth a new
21 progression plan on gender identity in the next few weeks. We have been instrumental in
22 informing the Department about our own efforts.

23 All of our programs at SAMHSA collect information on gender identity,
24 which is unheard of. All of our programs do. Some of our programs collect information

1 on sexual orientation, which, really, this is why they are looking to us for leadership in
2 this area.

3 You have it as part of your handouts, the actual wording of the measure.
4 The measure is in English and in Spanish. There were 139 cognitive interviews
5 conducted by the National Center for Health Statistics. They revised and finalized the
6 actual measure. They tested the methodology via CASI. They are now doing a
7 nationally representative split sample, English and Spanish. This is stage 3B. That will
8 conclude in June. The last stage is a 5,000 household representative sample to seal the
9 deal and validate the question for inclusion and integration in 2013.

10 We have come a long way in LGBT health. I said this on the call
11 yesterday with our national stakeholders. Since the days of Kameny in the 1950's to
12 now, we have come a long way. Yet, we still have a lot of work to do. We have a lot of
13 work to do in prevention. We have a lot of work to do in social justice.

14 Very recently, I am unsure if you are aware, but there were some
15 homophobic and transphobic events in the DC area where a gay man was shot and
16 another gay man was brutally beaten and a transgender woman was also beaten. Again,
17 we have a lot of work to do. We have come a long way. I think it is important to take a
18 step back, pat ourselves on the back, and continue to be leaders in LGBT health.

19 You may keep hearing this Section 4302 of the Affordable Care Act. This
20 is critical because of many reasons. One, it requires that the Secretary standardize how
21 we collect critical demographic information across federal surveys. This includes age,
22 race, ethnicity, language preference.

23 We are now using Section 4302, which also allows the Secretary to
24 include additional demographic variables in a standard way across federal surveys, the

1 Department is looking at how can we standardize socioeconomic status so that we have a
2 common definition for that at a population level and how then can we measure sexual
3 orientation across all federal surveys. This is why we are leading the efforts in this area.

4 I want to wrap up with some questions for you guys if that is okay, unless
5 you want to react first and then I can ask you some questions. All right. They want to
6 hear the questions. Is that all right, Pam? I have your blessing? Okay. Just checking.
7 Chain of command -- ex-army. I was just checking the chain of command.

8 MS. HYDE: That's what you get for having army guys with you.

9 DR. CAMACHO: Right now, we want to know what opportunities or
10 areas, should SAMHSA focus on for advancing LGBT behavioral health in the next 12-
11 24 months. Where do you think, as a NAC, SAMHSA should focus its efforts through
12 SGMIG for advancing LGBT behavioral health in the short-term future? I will just start
13 with that one.

14 DR. WONG: Well, I think you got a focus in K -12. I told you I was a
15 director of crisis teams for LA Unified. One of the crisis team calls I remember quite
16 vividly was a student in high school, who had come out, and the Principal couldn't decide
17 what bathroom he should go into. This is amazing work. It is excellent work. But how
18 does that translate into a specific system. I think education -- I will just say this -- it is a
19 closed system. It doesn't necessarily look outside itself to gain the information that you
20 have so carefully put together.

21 The other thing that really troubled my mind was it reminded me of a
22 school shooting that I worked on with some people in Oxnard, California, in which, again
23 -- I don't know if this young man was in the beginning of his transgender process or
24 whether he just enjoyed -- wanted to dress in female clothing, but he came out. He was

1 encouraged by one of his teachers, who was also a gay woman, to express his love of this
2 other young man who was not gay. He did so. He picked one of the most troubled young
3 men in the school. The young man was trying to stop this from happening.

4 It was one of the most tragic stories I think I have ever heard where the
5 teacher was encouraging him, the other young man had come from a troubled
6 background, and the bottom line was he shot and killed this boy. Clearly, this was a
7 school that could have benefited from guidance. We talk about cultural diversity and
8 different groups, but we have to keep making the process of inclusion greater and wider.

9 I think that there isn't a high school, middle school, maybe even some
10 grammar schools in this country, who couldn't benefit from some guidance about what
11 do you do with a child who is beginning to experience and understand his or her identity.
12 For me, I think it is amazing information. I think it has to be brought and focused on a
13 system, on an institution that is not necessarily going to look at your work and be able to
14 say, ah, I understand how that works now and I can apply it in this situation.

15 DR. CAMACHO: Thank you so much. As you were speaking, I thought
16 of two things. One is there is actually a fact sheet that talks about gender identity and
17 how we have moved away from the exclusive binary paradigm, but there is always the
18 bathroom dilemma. I will explain what that means. It is that even though we have come
19 a long way and we say we want to respect and validate a person's sense of self, gender
20 expression, gender identity, even if they are gender non-conforming, the signs on the
21 bathroom do not respect or validate that.

22 If a person is non-conforming, why should they choose whether to go into
23 a female restroom or a male restroom? When I was working in the field under New York
24 State Oasis, we removed all of the signs and just said restroom because we did not want

1 to devalue a person's own sense of self. I take what you are saying absolutely. I think
2 that such a simple change can have such a dramatic impact in the lives of transgender
3 individuals because you validate their sense of self by not making them choose whether
4 or not they should use a restroom based on their anatomical makeup.

5 DR. WONG: I think what happens is it is a far more complex situation.
6 Let's say in this one school -- it was a school in a Latino community. There were a lot of
7 young men, some of whom were involved in gangs. It is a system where there are all of
8 these moving parts. How does an administrator take and respect what this young person
9 is going through in the dynamics that are beyond just the one-to-one situation? I think it
10 is your work at this level that can appreciate that complexity. Still, they need to go to a
11 place where they can get guidance about how do I deal with this.

12 MS. HYDE: Other comments?

13 DR. STEIN: Strategic initiative number one -- the systems of care one for
14 the workgroup, how is that being translated out to the systems of care programs across
15 the nation?

16 DR. CRAFT: That is a Center for Mental Health Services program. I
17 know Michelle would have a lot more to say about that if she were here, but I do know
18 they have a mechanism in place where they are pushing out that information. They do
19 have contacts.

20 DR. HUANG: I can say a little about that, Flo. The system of care
21 program is probably one of our only programs that collect not only transgender, but
22 sexual identity and sex orientation data from the youth involved in that program. They
23 probably have about 200-300 youth that have self-identified. They don't have programs
24 that are specific to that population, but you can self-identify within.

1 They have done some interesting analyses on that. That is where we have
2 gotten this work on looking at family acceptance or family rejection in families and some
3 beginning data that that program has supported, looking at the association between family
4 rejection and homelessness, suicide attempts, depression, and runaway among youth. It
5 is not a requirement of the program or specific. They also have several issue briefs they
6 have put together as guidance. As you were talking, Marleen, those guidance materials,
7 which, again, are focusing on youth might be useful for schools as well.

8 DR. STEIN: This is mostly going on with your SOC grantees. I am just
9 wondering are you presenting it at the national child mental health meetings so that it is
10 getting out to other systems of care? We have three grantees right now, probably, but we
11 have taken system of care to scale so every single one of our mental health centers does
12 systems of care. I just don't know if we are getting this incorporated into what we are
13 doing. I don't know where we are telling everybody about it.

14 DR. CAMACHO: If I may, I also wanted to bring to the forefront that
15 CSAP's Minority Aids Initiative has 122 grantees, of which 52 target LGBT populations.
16 I am spearheading the first LGBT-specific evaluation of that program using the minority
17 stress model as a framework. We will be showcasing those results at the National
18 Prevention Network Research Conference this year and also making those documents
19 available.

20 This program is very unique. It is integrated prevention of Substance
21 Abuse and HIV. We believe that if you reduce substance use behaviors, you reduce the
22 risk of HIV transmission and infection. Understanding the substance use behaviors of
23 LGBT populations are critical. It reflects a census, which is not a probability sample.
24 Yes, there are limitations about the extent to which you can generalize these findings, but

1 for program management purposes, we need to know where the successes are with these
2 populations.

3 Where can we strengthen this? Who needs to know so that state
4 governments can then, in turn, support their communities funded through either the MAI
5 program or any other program that SAMHSA offers. That is one way we are addressing
6 this very issue of dissemination and integration.

7 DR. MARSH: I don't specifically the answer to your question, but I will
8 find out.

9 DR. HUANG: One other thing, if your communities participate in your
10 system of care meetings, they always have a track around LGBT. That will be Orlando
11 this year. It is every other year. There will be a webpage for LGBT coming soon,
12 probably next month. A lot of these resources will be on that page, here, at SAMHSA.

13 DR. CRAFT: May I ask a couple of questions? First of all, I wanted to
14 add a couple of things that I didn't mention in my presentation. One is we do have -- I
15 am sure all of you know -- what is referred to as concept clearance for a LGBT TIP,
16 Treatment and Improvement Protocol, which you are probably aware of. We are very
17 excited about that. We will actually go through the TIP process in developing this, using
18 experts from the field, stakeholders.

19 It will be very much a research-based, evidence-based document that will
20 replace the Provider's Guide. The Provider's Guide is about ten years old, although, the
21 TIP will comprehensively cover behavioral health and not just substance abuse treatment.

22 Also, I just wanted to mention that our block grants to states have now
23 included language in their application that encourages states to identify and meet the
24 needs of LGBT individuals.

1 I had a couple of questions that I wanted to ask, as well, to you all. One is
2 one of the things that I keep hearing about as I go out to various meetings is this gap
3 between various socioeconomic levels of LGBT individuals and how do you think about
4 and address that in developing materials and meeting those people's needs?

5 A lot of the lower socioeconomic status folks, even though many of them -
6 - we serve many of that demographic, are not getting services. Part of it is because things
7 are not developed in a way that meets their needs. Do you have any thoughts about that?

8 DR. STEIN: Do you mean they're not getting equal access to health care
9 or to behavioral health or both?

10 DR. CRAFT: Well, both of those issues, but also a lot of the materials
11 that are going out do not meet their specific needs, looking at adapting and modifying
12 some of the material that we are sending out to address all levels of severe economic
13 strata.

14 DR. LEMELLE: I guess it's not clear to me how you're making the
15 distinction. If you are talking about socioeconomics, are you addressing issues of
16 poverty and that because people are poor they don't have good access to care or because
17 they are poor they don't have access to the same type of education or is there something
18 more specific that you are referring to?

19 DR. CRAFT: I think it is just a lot of people lump L, G, B, and T together
20 when they are really very different populations. The issue here is if you had someone
21 upper middleclass, very well educated, has a job, has all of their basic needs met,
22 providing services to them is very different than if you have someone who is poor, may
23 not even have their basic needs met, may be homeless -- so to adapt.

1 This is not something that is coming directly from me. This is something
2 that I hear out in the field. I was at the Creating Change conference in Baltimore a few
3 months ago, which is the annual conference of the Gay and Lesbian Taskforce. This was
4 an issue that they just didn't feel that these groups were getting what they need.

5 DR. WONG: Excuse me, I guess I think a little differently about that
6 because when I worked for LA Unified School District it is 90 percent minority. It is 75
7 percent free and reduced lunch. I think of it more from a developmental perspective.
8 What do we need to help educators do to support and protect children from a
9 developmental perspective? What might you guide them with with respect to elementary
10 school children? How does that change for middle school? In high school, as they begin
11 to mature and they are moving towards more adult issues, how does that differ? I guess I
12 just don't have enough experience with what that means about looking at it from the
13 perspective of SES factors.

14 DR. HUANG: I just want to maybe add to Ed's question, not that we can
15 really answer it today in the last five minutes. I think there is looking at different
16 demographics that intersect with this particular population. We have often done some
17 work with -- in fact, the Family Acceptance Project focuses on racial and ethnic
18 communities of LGBT populations.

19 How that is understood in different cultural groups, how it is accepted, and
20 how it is supported also really varies. That is like a subpopulation of a subgroup
21 population already. As you are looking at multiple intersects of those populations, it
22 means that the guidance we put out has to be not just attuned to a broader population, but
23 to the different cultural, racial, and ethnic needs, socioeconomic needs as well of this
24 population.

1 I think it is a broad question. It is a challenging question. I am not sure
2 that we can really get it answered here.

3 DR. CRAFT: Yes, but it is something I really just wanted folks to think
4 about. I didn't expect -- like you said -- to get a really specific answer. The other thing
5 that I would like for you to think about and you might have some thoughts about it today
6 is we have a difficult time identifying evidence-based practices, particularly for LGBT
7 populations. That is one of the reasons why we are developing the TIP.

8 I know there are a few products that have been modified to serve LGBT
9 populations, but I am wondering if you all are seeing anything out in the field because
10 what we would like to do is identify where practices are not formally yet evidence based,
11 but where there are things that are working where we can make connection with those
12 programs, communities, whatever and help them get involved in the NREPP process if
13 that is appropriate or wherever it fits.

14 We would hope it would be something that we could put through our
15 NREPP process and then have it listed for all providers. Several of our grant programs
16 require these evidence-based practices. It would be really helpful to have some in there,
17 specifically for this population as we move forward in being more inclusive in our grants
18 and contracts.

19 DR. LEMELLE: I think one of the issues -- as you were talking I was just
20 thinking about this -- is in terms of how you are looking at or how we are looking at this
21 population. I think one issue is sort of, in general, cultural competence, no matter what
22 the cultural subgroup is. People can be minorities in a social setting for multiple reasons,
23 including gender identity.

1 I think when you are talking about somebody's sexual habits that is a very
2 different sort of domain. I think there are lots of good evidence based practices for
3 understanding cultural competence on multiple levels, including all different cultural
4 issues.

5 If you are talking more about sexuality, I think that is more of a medical
6 model. There are certainly medical approaches to how do you do a sexual interview, how
7 do you talk with people about their sexuality. There are lots of good evidence-based
8 practices around those issues. I think that, to my knowledge, I don't know of any
9 evidence-based practices that actually necessarily blend the two. I think there are so
10 many variables involved in each. There are certainly good evidence-based practices in
11 terms of understanding someone's sexuality and certainly there is good evidence for
12 cultural competency as well.

13 DR. CRAFT: That is very helpful. Thank you. One I was referring to is
14 there is a lot of cultural competency training out there that teaches providers how to
15 interact in a culturally competent manner with LGBT people, making the environment
16 welcoming, filling out the forms, and so forth.

17 We have, for example, the MATRIX model, which I am sure you are
18 familiar with that. They have done several adaptations. There is one for Native
19 Americans, one for gay and bisexual men. We just finished a piece on meeting the needs
20 of women. That is what I am talking about -- whether it is an adaptation of an existing
21 practice or a unique practice -- I am really talking about treatment and prevention
22 protocols, the actual treatment.

23 MS. HYDE: All right. I am going to play a little timekeeper here because
24 we are getting close. You can see that we are hungry for advice a little bit in this area,

1 yet we have lots of great stuff that has been going on. I want to thank Ed, who has been
2 staffing me on some of these issues for the last year or year and half or however long it
3 has been.

4 Alex, I want to call out because he is one of our ACE Fellows, which is a
5 program that we have been doing around developing internal capacity. Alex went
6 through the first program, which, actually, Rich has led the program for us, which we are
7 maybe eventually going to get most of the employees to go through. Alex is an up and
8 coming leader.

9 Actually, I want to thank Larke a lot. She does seventy hundred things,
10 but one of the things that she does is work with and manage and lead these groups on
11 everything from soup to nuts and everything in between. Thank you, Larke, for doing
12 that.

13 I just want to close this part, unless anybody else has other things. Any
14 other comments or reactions to what you have heard about this?

15 I just wanted to react to a couple of things. Marleen, when you told the
16 story about the bathroom issue I was reminded of when I was a first mental health
17 commissioner I was fairly young. I was 32 or something like that when I became
18 commissioner initially. That is how come Dee and I have known each other for so long.
19 I am really old now, Dee. I don't know about you, but that was a long time ago.

20 I can remember we ran a forensic facility for corrections. We had people
21 in a hospital that was under court order that had people in it who had literally been
22 convicted and were in the correctional system, but who had major behavioral health
23 issues. It was kind of a whole mix. It could anything from people who hadn't actually
24 been convicted yet, guilty by reason of insanity or not guilty by reason of insanity, or

1 people who had actually been convicted and needed to be separated from general population
2 and had pretty serious issues.

3 I can remember, as a young commissioner, getting a call about a person
4 who was there and they didn't know whether he or she was a male or a female and didn't
5 know where to put him. Obviously, in those settings in that day and age, you didn't have
6 co-ed dorms, wings, whatever. You had to be one or the other. I remember coming to
7 the realization as a young woman, as a young lesbian woman, as a young commissioner
8 that you have to be one or the other in this world.

9 There was something about that experience for me just thinking the whole
10 world is split into two. I hadn't ever really thought about it that way before. That was
11 kind of my entrance into the concept transgender or gender difference or whatever was to
12 understand how hard that must be to live in a world that is so one or the other. If you are
13 either going through the process or people view you as one way and you are presenting as
14 another way or you started life as one way and you are now not that way -- anyway, that
15 experience really said something to me. I have sort of carried that experience with me.

16 The other sort of personal experience about this -- I think Ed and Alex
17 both were talking about it in different ways -- is LGBT is at least four different
18 populations, if not fifty hundred others. Lesbians are not the same as gay men, who are
19 not the same as bisexual gay men or women, who are not the same as transgender. In
20 fact, transgender people are not gay necessarily. Some of them are, but not all of them.
21 It is just totally confusing. We kind of put these folks into a group because we don't
22 know where else to put them, but they are really multiple populations.

23 We didn't even really talk about the two spirit concept. I was very struck
24 when we had the two spirit individual talking to us. I have now heard several different

1 folks talk about the fact that the only way people can understand it is in gay and lesbian
2 terms, but that is not what it is. It is not that at all. It is almost a spiritual issue.

3 There is just complexity to this population as there is with any population
4 group. I think the question that we are being asked -- just because you are one of those
5 four things doesn't mean you are not something else if you are 62 as opposed to 32 or if
6 you were raised in Missouri versus if you were raised in an affluent home in the
7 Northeast. There are all of these complexities. We have a tendency to put people into
8 boxes.

9 I think, actually, behavioral health does a good job of at least saying we
10 want to take the person as they come to us. In fact, we don't really do that. We really put
11 people into boxes and try to react to them in that way. It is complex. I think as we drill
12 down into the behavioral health equities issue, instead of coming back to you or to the
13 larger group and doing another let us tell you all of the things we are doing about LGBT
14 work, we actually want to drill down into some of these populations.

15 Yesterday, different people raised the issue of the relationship between
16 evidence-based practices and -- I have a hard time with the word minority because I come
17 from a state where there is no majority. It is three populations at least. Anyway, how do
18 we do that and what is the relationship? I am now pontificating. I will stop. You get the
19 point. These are hugely complex issues. I think it is more than just making sure a
20 subpopulation gets good treatment or care. It is really sort of fundamental to how we
21 think about our approach to people and their needs as they present or as we try to prevent
22 issues that they may experience.

23 I will tell you one more story. It also reminds me as a young person when
24 going to the bars stopped being of any interest and yet that was the only place where you

1 could socialize because it was illegal or for whatever reason. There was a bar in a town
2 that I lived in that actually started having happy hour until seven or eight o'clock -- eight
3 o'clock, I think. They had special programming, music, and everything else, drinks, for
4 people over 40. At eight o'clock or nine o'clock, they start the programs or their
5 commercial offering for people under 40.

6 Obviously, you could go to either place, but it was fascinating to see how
7 many of the over 40 people came out -- no pun intended -- to the earlier program because
8 they wanted to be home by eight o'clock for criminey Christmas and because they didn't
9 want to drink a bunch of alcohol and because they wanted, frankly, 60's music, not 80's
10 music or whatever it was at the time. If commercial folks can do this -- and they got lots
11 more business that way.

12 Anyway, it was also something that reminded me you just have to think
13 about what is it that people need and want and what can we do for them? Thanks to the
14 panel. I appreciate it tons. I appreciate your work.

15 We are going to break and have some lunch. However, it is that we are
16 not feeding you. See, we have to go find food. Let's see, we are just a little bit late so
17 why don't we come back at -- can you still make it back by 1:00 PM? Great. We will
18 start back at 1:00 PM. Thank you.

19 (Whereupon, a luncheon recess was taken.)

20

AFTERNOON SESSION

1

Agenda item: Public Comment

2 MS. HYDE: We had one person who was interested in doing public
3 comment. That person sent us a piece of paper. I now can't put my hand on it. What
4 happened to it? Is that it? Yes. This is a summary. It is from a person named Deacon
5 Donald Clark, who is interested in stuff. We will have copies for you, but we will see if
6 this person is available after we get through with these two pieces of information. If not,
7 we will tell you the essence of it and go from there.
8

9 You had some information, Anna, from a question earlier?
10

11

Agenda Item: Other topics

12 DR. MARSH: Yes. I was asked earlier what we're doing in the area of
13 supported employment. I have since then learned much more about this so I wanted to
14 share it with you.

15 We have a toolkit on supported employment, which is available through
16 the website. If anybody wants it, I have one copy here. We also have a project through
17 our state division, which provides incentives and supports to state mental health
18 authorities in collaboration with substance abuse authorities to increase employment
19 opportunities for people with mental illness and substance use disorders. We have been
20 putting a little over a million dollars annually into that, although I am not sure we are able
21 to sustain that this year.

22 We also have some interagency agreements with the Department of
23 Education, the National Institute on Disability and Rehabilitation Research. Through one
24 of them, we fund the University of Illinois to address improved co-occurring health,

1 wellness, and employment outcomes for individuals with psychiatric disabilities. There
2 is a second one that funds Boston University to address improved employment outcomes
3 for individuals with psychiatric disabilities. Each of those is about \$300,000 a year. We
4 have been doing those, I think, annually for a while.

5 I just wanted to let you know there was more than I knew this morning.

6 MS. HYDE: Thank you. I thought we had some little bits and pieces. I
7 knew it wouldn't have a major portfolio, but I thought we had little bits and pieces. WE
8 do define recovery in such a way that purpose is one of the four domains. We defined it
9 as purpose because obviously job doesn't always work for young people. Their purpose
10 might be school. Frankly, there are also some people who are seniors who might not like
11 to work anymore. They might like to be retired. There are also people who want to be
12 self-employed or do their art or do other kinds of expression.

13 Purpose is the way we defined it, but it is one of the four domains. To the
14 extent that we are looking at defining recovery and Pete is trying to think about measures
15 of recovery and all of that good stuff, sometimes we look at the issue of employment or
16 school or purpose in peoples' lives. Still, a lot more we could or should do, Stephanie,
17 but thank you, Anna.

18 Stephanie, you also wanted to share some stuff with the committee.

19 DR. LEMELLE: So this is something I think I spoke with everybody
20 about last year. It has to do with healthcare disparities, minorities, and access to care. I
21 think I was thinking about it -- the logo that treatment is effective. I was thinking, yes,
22 treatment is only effective if you actually have access to the treatment.

23 What I wanted to present is this concept of benign ethnic neutropenia,
24 which is, as the name implies, a benign state that some minority groups have of a low

1 white blood cell count at baseline. If we were just to go around the room and measure
2 everybody's white blood cell count, some people have a low baseline white blood cell
3 count. It is benign because it doesn't have any health implication. It doesn't mean they
4 are more at risk for infections or having any other problems.

5 The reason that this is important is because one of the antipsychotics that
6 we have in our armamentarium, Clozaril, is sort of the antipsychotic of last resort. It is
7 only used in people who have not successfully been treated with other antipsychotics.
8 Part of the reason it is categorized in this way is because it is a really good antipsychotic
9 and it really works for people who have had resistance or not a complete response to
10 other antipsychotics. Part of the reason it is a second line medication is because in one to
11 two percent of the population that use it, they actually drop their white cell counts.

12 Their white cell count goes down in response to taking the medication.
13 Because of it, the FDA has a requirement for having white blood cell baseline count
14 before you can even start a trial of the medication. If your white cell count is below the
15 cutoff for the Clozaril registry, you are not eligible to try the medication.

16 I am raising this because that means there are lots of people who are
17 minorities, particularly African Americans and people of Middle Eastern descent, who
18 have this normal white blood cell count that is low who are not eligible for this
19 medication. This is a medication that is often used in state hospitals and long-term
20 settings where people are too ill to be released from the hospital. These are folks who
21 end up staying hospitalized when they potentially could be discharged if they had access
22 to this medication, but because the standard is based on a population other than theirs,
23 they are not eligible.

1 One of the things I have been talking with Fran about and with SAMHSA
2 about is talking to the FDA about possibly modifying the criteria for the white blood cell
3 count. This has been done in the United Kingdom. It has also been done in Ireland.
4 They have two different standards. They have a standard for people who have benign
5 ethnic neutropenia and then they have a standard for everyone else. They have
6 successfully used Clozaril in folks with this new standard.

7 It is something that the FDA has not done in the United States. There is
8 plenty of literature that supports this. We were hoping that by presenting this to the FDA
9 that they would reconsider using a different standard or think about using a different
10 standard.

11 I think it raises the other issue of cultural competence and how we study
12 things, how we look at things. Clozaril has been out for 20 years. 20 years ago, the drug
13 trials were done primarily in white men. The white blood cell count standard was based
14 on white men. I think that now most agencies that support research think about
15 diversifying the research subject, but this is just a perfect example of how it is crucial to
16 have a diverse subject population that we are doing studies on so we don't have this type
17 of oversight.

18 MS. HYDE: Comments? Anybody have any comments they want to
19 make about this?

20 DR. SPRINGGATE: I appreciate very much what you've expressed. I
21 think that it sounds like it does deserve a further look into potentially by FDA. I am
22 reminded of very commonly used medications, such as ACE inhibitors, which are a form
23 of blood pressure control medication, which are also good for patients with diabetes and
24 protecting their kidneys, or statins, which are used to control cholesterol.

1 For a long period of time, it was recommended that there be regular testing
2 of the creatinine, the kidney function, for patients who were on ACE inhibitors and
3 regular testing of liver enzymes for patients who were on statins. As it turns out, yes,
4 those medications do have potential side effects in those organ systems, but, as it turns
5 out, the notion that there needs to be regular testing for everybody turns out not to be very
6 effective and ends up limiting the benefit. It was subsequently rescinded. That degree of
7 testing isn't required.

8 I can certainly see how in a population like you are describing that there is
9 the possibility that patients are simply not getting treatment that would be very helpful for
10 them and that the risks, maybe based on what you stated, may be overstated.

11 MS. HYDE: Other comments? Okay, I think we're still working on the
12 NRT, Nicotine Replacement Therapy issue. Actually, we recently brought it up -- I
13 won't bore you with the details, but a meeting I was in in which I was able to say are
14 there pending things that aren't getting dealt with. I raised it. FDA is looking again at
15 what happened to the letter. We had to send it again because they had lost it. These
16 things happen.

17 I thought on this one, Stephanie, it might be good -- because there is some
18 combination of the research that has to support the theory. It might be worth maybe
19 getting a phone call or a meeting if you are ever down this way, but certainly a meeting
20 with maybe some folks from NIMH and folks from FDA and see if we can just talk about
21 the issue and see what it would take.

22 What would FDA need to get that? I think it is pretty clear that just the
23 plain letter isn't the way to get their attention, although the letter allows me to raise it in
24 other settings. Nevertheless, if you are willing, we will call on you to help us do that if

1 we can get a conversation going about that. I know you have been working with Fran on
2 that also.

3 DR. HARDING: Dr. Clark is a partner on this and probably Peter soon.
4 We have been working with Bob's group. We are waiting to hear what the directive was
5 of the NAC before we went any further. I will pull together someone from treatment, as
6 well as our two residents, who have been helping put this together. Most of you who
7 work with me know this is not my area of expertise, but I have learned a whole lot.
8 Thank you.

9 MS. HYDE: Clearly, CMHS needs to be part of this one. This would be a
10 great place if we had a CMO, a Chief Medical Officer, we would ask that person to lead
11 for us. I might just use this opportunity to say one more word about that. I mentioned it
12 yesterday, but we only have so much HR capacity. We only have so much ability to push
13 things through. They have also been downtown redoing the way we deal with and
14 manage human resource issues.

15 We sort of sometimes have to pick and choose what the priorities are.
16 Clearly, getting the OPPI structure in place, getting the DFR switch and the ONTO
17 switch and all of those things were priorities. Now, getting some of this in-sourcing work
18 that you heard about yesterday done has been a priority. If you just listen to when we are
19 introducing people, there are lots of acting physicians in lots of places and lots of people
20 doing two jobs because the person under them isn't filled and stuff like that.

21 We are having to prioritize HR issues. It is part of the reason why the
22 CMO issue has not gotten pushed a little harder. In addition to which, I think since we
23 didn't really find the person we wanted or the persons we found weren't willing to come,

1 either one or the other, we sort of stepped back and thought we would wait until the OPPI
2 Director got here and then start up again on trying to get a CMO.

3 If anybody has ideas about people, it really does take, as Kana said
4 yesterday, a physician that also knows substance abuse and mental health, both, that has
5 some sense of prevention as well as treatment and recovery, has that philosophy, is
6 willing to come and work for the government, is willing to live here, is willing to take the
7 salaries that we can provide. You put all of those together, that is a tough thing to find,
8 and understands financing public policy issues. These are big issues. If anybody knows
9 anybody like that, there are a few of them out there and we just need to find them.

10 All right. Good. Thank you, Stephanie. Is there anything else of general
11 nature that anybody wants to raise? Any thoughts about -- we have had a little bit of
12 conversation about it, but the question I asked you earlier about what would you propose
13 that we do next? We are a little bit inhibited, I think, at this point, about considering
14 having meetings anywhere else. I think at least for August we are going to stay here. It
15 is, in fact, cheaper to stay here.

16 Anything else that comes to your mind, about next steps for a meeting?

17 DR. ROTH: Just a procedural detail, some people were talking this
18 morning that August had already been set. If it has, can we please know when it is?

19 MS. HYDE: Yes. I'm sorry. I thought we had told you that. It is August
20 8th, 9th, and 10th. It is a Wednesday, Thursday, Friday.

21 DR. ROTH: For us it would be 9th and 10th?

22 MS. HYDE: Yes, probably. Again, I apologize, but we have to set those
23 dates pretty far in advance on some combination of what else is going on in the world
24 that we can't overlap with and schedules and room availability and a variety of things

1 that we have to set. I apologize. I know August is not the most perfect time. People
2 have vacations and kids and other things that they deal with, but there is no perfect time.

3 DR. ROTH: Knowing this far in advance helps.

4 MS. HYDE: Chris asked yesterday if we could have the same week in the
5 spring and the same week in the summer or fall. I don't know if that is possible because
6 there are always things happening that we don't control. We could try to do something
7 similar to what we did this year if that makes some sense. Any time you hit the spring,
8 you are hitting potential spring breaks and things like that. We try to do the best we can.

9 Any other comments about next meetings? We also -- I don't want to be
10 doomsday about this and I don't feel that way, but I wouldn't put past the fact that if the
11 budgets keep constraining in the way that they are, we may have to figure out ways to do
12 some non-face-to-face conversations as well. I don't think -- are we required to meet
13 twice a year? We have that requirement, but I think we can do it by phone. If it got that
14 difficult, sometimes those kinds of dollars don't save us that much, but the perception of
15 what we are doing with those kinds of things is important.

16 Any other things that you want to raise about next meetings or otherwise?
17 All right, at the risk of raising something that may be touchy, let me just tell you one
18 other thing that we have discussed in the past. Please don't in any way, shape, or form,
19 think that this is a proposal. I am just asking your interest or your thoughts.

20 We are a relatively small agency. We have seven advisory committees.
21 One you don't interact with a lot because it is a regulatory advisory committee. It is
22 about drug testing. We have people on there who are laboratory specialists and very sort
23 of technical specialists about drug testing mechanisms and processes.

1 We have sort of thought about, probably in the context if we ever got back
2 to the issue of authorization -- that is a big issue, too, reauthorization -- but if we were
3 ever to get back to that issue, we probably would have to cross the bridge of asking the
4 question should we have so many advisory committees? Should we have less? If so,
5 what should they look like?

6 As you know, right now, we have the women's services one, we have the
7 tribal one, we have the three programmatic center ones, and we have this one. You have
8 now participated in the big groups. You have seen what kind of conversations we have.
9 I don't know how many of you have either participated in or sat in some of the other
10 ones. Do you have thoughts about this after the experience that you have had in the last
11 couple years?

12 DR. STEIN: We were just having this conversation this breakfast, a
13 couple of us, about what were all of these groups. That is what people were asking me.
14 One person was asking me who was on the women's advisory group and wanted to know
15 what we did. I think I said that I thought the specialty groups had sometimes more
16 interesting programs than we do. I don't know. I think it is a question that can certainly
17 be asked and we can explore it.

18 DR. LEMELLE: Again, in terms of efficiency, I wonder if -- I feel like I
19 get a lot out of the big meeting where we get snippets about what all of these other
20 smaller groups are doing. I wonder if instead of having standing advisory groups, if there
21 was just one advisory group that has workgroups that get created outside of this larger
22 group where you can sort of have people volunteer to work on a particular area and bring
23 the information back.

1 You can probably squeeze the number down if you did it that way.
2 Choose people who had expertise maybe in multiple areas or interest in multiple areas.
3 Have breakouts from one sort of clustered group.

4 I think the shared information and having an ability to discuss things in a
5 shared way is really useful, but when you are trying to get something done you need a
6 smaller group. Maybe it doesn't have to be a separate group. It doesn't have to be a
7 standing group. It could be an as-needed work group.

8 DR. SPRINGGATE: I am recognizing the financial pressures. The risk,
9 of course, is that some group, depending on which group would not be continued
10 potentially or continued in a different way would feel that it had been discontinued and
11 thus is it less of a priority? You are obviously aware of that. Some creative arrangement
12 that somehow manages to lower the costs associated with it -- the ones that you proposed,
13 maybe it is one in person and one over the phone meeting, which may serve a relevant
14 purpose.

15 MS. HYDE: Thoughts about this?

16 DR. WONG: Having once experienced being eliminated from a whole
17 board at the IOM, it felt as though whatever our interests were, it wasn't acknowledged
18 that somehow it should be merged with the other group because we did have a special
19 focus on neuroscience behavioral stuff. I think it is really a question of whether or not
20 the groups serve the objective of the organization. Even if there were to be an
21 elimination, maybe somehow some of those members could be at first merged instead of
22 being just completely eliminated.

23 DR. STEIN: This is a different perspective, but from a state perspective,
24 we are actually going in the opposite direction. We are feeling the need to get more

1 people to the table to interact directly with us, even though we have no days or hours left
2 in any week. The pressure for inclusion of stakeholders, consumers, decision makers, et
3 cetera is huge. It is getting bigger. Especially during transition, people are wanting to
4 hear directly from you. That is just another perspective.

5 MS. HYDE: On that point, actually on both of those points, I think if we
6 were to try to do something to change any of these groups, it would become a who don't
7 you like conversation. In fact, I think we are doing more of what you just said. They are
8 just not formal, FACA, appointed advisory committees.

9 We meet constantly with stakeholders in a variety of ways and settings.
10 We are probably doing more of that by virtue of the very reason that you said. There is
11 so much change going on. There are stakeholder meetings every other -- there used to be
12 stakeholder meetings every month because of health reform. Now, they are every other
13 month. Probably three or four times a year, we call stakeholders together, the major
14 stakeholder organizations, to talk about everything from budget to whatever is going on.

15 There is a lot of that conversation going on, but nobody would see that.
16 They would just see what we are eliminating, at least in terms of formal advisory
17 committees. That is the frustration or the pressure. How do we make these things
18 legitimate and relevant and not waste your time and not waste our time? I get tons from
19 it. I keep telling you that, but we really do get tons from it. I know that it is a lot of time
20 and commitment on all of your parts as well. Did you want to add something else here?

21 DR. LEMELLE: I think, and this just from my experience running a
22 board, by having a core group of standing people, I, by no means, meant to eliminate the
23 input of all of the other folks. It is just that the active decision-making is smaller group.
24 Clearly, you bring in tons of other people and other voices. The structure of the system is

1 reduced. The voice and the communication can be expanded from the smaller base. I
2 guess that was sort of my point, not that we should eliminate the communication, but just
3 the standing structure of it.

4 MS. HYDE: I agree. I think we were just responding to what the
5 perception is about that.

6 DR. SPRINGGATE: I think the difference between this Council structure
7 or these councils and a board, on a board there is actually an emphasis on having a group
8 that can make decisions. Having that smaller focused group is important because you
9 can't have 500 people contributing efficiently to an organization's decisions.

10 In these instances, with the councils, the councils are not decision making.
11 The councils are intended to bring in perspectives. The participation of the communities
12 that are impacted by substance abuse and mental health is in a way that is recognized, I
13 think, is important and validating to the members of the community and to the
14 constituencies and populations that they represent.

15 MS. HYDE: Okay. Do you guys have a feeling about this group? Right
16 now, we have nine people on this group. We can have up to 12. The one perspective that
17 I feel is missing -- as you know, we tried to get that through Kate, who is no longer with
18 us, but we were really trying to get a Medicaid perspective because of all of the stuff that
19 is going on in the world with health reform at the moment. That perspective feels like it
20 is missing to me in this group, but otherwise we have a pretty broad perspective here.

21 I am curious -- this group has changed quite a big, this group meaning the
22 NAC, because we have been meeting together with all of the other ones. I am curious,
23 also, about what you think your best role is or how could we use you best and, again, not
24 waste your time, give you the right information, get from you the right stuff, et cetera?

1 DR. STEIN: Do we still have a youth member?

2 MS. HYDE: We do. That person wasn't able to be with us today, I think.
3 Some of you have now experienced this only once or twice, but some of you have
4 experienced it more where we meet afterwards and try to reflect on yesterday and then
5 also try to do some unique things here like delve into the common data platform issues in
6 way that we might not have at the larger meeting. Do you have any advice for us about
7 how best to use your time?

8 Some of you we have used individually, which I really like. Dee has
9 talked with Pete some. Stephanie, we have certainly talked with you about some
10 individual things. I anticipate using others of you maybe on more individual levels. In
11 terms of the Committee, we still have to meet -- as long as it exists, we still have to meet
12 twice a year. It doesn't say how long we have to meet. We just have to meet twice a
13 year. I want to make sure that we are using you in the best possible way as well. Do you
14 have thoughts about that?

15 DR. LEMELLE: I hate to volunteer for more stuff, but I was just thinking
16 about the fact that I didn't realize that we could have been here on Wednesday. I would
17 have like to hear the Substance Abuse Treatment and Prevention folks. We have gotten
18 the reports, but I would have liked to have heard what was actually said in the discussion.
19 I think that I have never been to one of the tribal meetings either.

20 When you have smaller groups then you miss something. If you have one
21 big large group, you miss something. I think it would be great if maybe it was a little bit
22 clearer to us that we have the option of sort of sitting in on some of the other groups. I
23 think actually hearing it is different than hearing a report about it.

24 MS. HYDE: Okay. That's a good input.

1 DR. ROTH: There's a definite tension between all the money stuff and
2 then having the experience be real enough to be meaningful. I had a little experience of
3 trying to do a big telephone meeting and that is just -- it really is cumbersome. You can
4 tell that people are sitting there doing their email and not paying attention.

5 To be here and to hear the stuff yesterday, gives me -- and being a brand
6 member, I am still trying to get the whole frame -- but helps me get that. I think it
7 wouldn't be as real an experience if we weren't physically here. I agree with Stephanie
8 that I had no idea we were able to go to any of the other meetings. That would be helpful
9 as well.

10 MS. HYDE: We could do your time a little differently. We have typically
11 done some of the other meetings the day before. We could do that and the big meeting
12 all together and then just end it soon enough that we could meet for an hour. That would
13 be the NAC meeting. Then you wouldn't have the whole other day. That is another way
14 to do it.

15 We are just trying to think about how to be most efficient, partly for the
16 money, but that is not really all of it. It is also about are we using you correctly and are
17 we getting the most we can from you? Again, you are giving us your time so we want to
18 make sure that we are doing that right.

19 I can tell you that the three programmatic centers have a function in law
20 that I think is pretty ridiculous, but it is there and we have to deal with it, which is they
21 theoretically have to approve grants, which is just kind of silly because the grant process
22 is so extensive. By the time it gets there, if I were a member of one of those committees,
23 I would say what are you asking of me? What am I putting on the line here, blessing,
24 because I have no clue if what you did was the right thing or not?

1 I think that is a little weird, but it was put in the law years ago, as I
2 understand it, to make sure there was some objectivity or whatever to the grant making
3 process, which there are all kinds of other processes now that are in place to do that kind
4 of objectivity.

5 DR. LEMELLE: Are the grants actually reviewed at the other meetings?

6 DR. MARSH: It's a review of the peer review process. The council
7 members don't get the grant applications, themselves. I think they get the summary
8 statements. They have to bless that the process was done correctly.

9 DR. KOPANON: That is correct. They don't really have any option to
10 comment or change any of the grant applications.

11 DR. MARSH: It used to be, before 2000, that the councils had to also
12 bless the contract awards. That got changed in the Children's Mental Health Act. It used
13 to be the SAMHSA Councils actually had to review the contracts that were being
14 awarded for the Offices. Each Center Council reviewed the contracts and the grants for
15 the Centers. The law changed. It took out the contracts, but left the grants in.

16 DR. LEMELLE: That's kind of weird. That is kind of like going to the
17 distinction that Ben was making between a board and an advisory committee. A board
18 would be responsible for understanding what is being produced as opposed to advising
19 about trends and directions. That just seems kind of weird.

20 MS. HYDE: Yes. It is just something we're living with in the law. Until
21 we get some ability to get the reauthorization back on the table, which we might take up
22 next year -- we will see. We will see how the politics of it look and whether or not the
23 politics in Congress -- as we said the other day, the thing that is preventing
24 reauthorization in some ways has nothing to do with all of the behavioral health stuff. It

1 has to do with another political issue having to do with faith and religion and stuff,
2 charitable choice things.

3 If I were a committee member on one of those committees, I would be
4 saying -- of course, it would probably be my lawyer hat on -- saying I don't want
5 anything to do with blessing this process. I don't know enough about it. Nevertheless,
6 that is what is in the law.

7 Interestingly enough, we also have the ability to waive it if we can say
8 why. Sometimes, not always -- we don't do it constantly, but once in a while if we have
9 a real time problem and we can't get the group together or whatever then I waive that
10 requirement. That seems kind of silly, too. If I can waive it and I don't have anything to
11 do with the selection process, nothing, nada -- I am not involved in that in any way,
12 shape, or form. It just seems strange. That is another piece that we are sort of looking
13 at.

14 DR. SPRINGGATE: Along the line of your question of how can we best
15 serve the interests of the institution, I was hearing from Fran earlier about her council and
16 how there may be, for instance, draft reports that are approaching final release. You have
17 circulated such a report to your members. They have a month to get back to you,
18 however long it may be, and that type of a thing and that level of engagement on
19 something that is meaningful and relevant to the organization, not down in the weeds
20 with the subject matter experts, who have already worked through it, but providing some
21 feedback may be another opportunity that is not labor intensive. It could be an
22 opportunity to get some additional value out of the organizational members.

23 MS. HYDE: I think the thing that we just gave you today, you can think
24 of it in that way. The pre-decisional things, as I understand it, we can give to you, but

1 you can't give further and you can comment to us. Feel free to do that on the evaluation
2 thing. It does need to be finished. We have been through forty hundred versions of it. It
3 needs to be signed off on and blessed. Your thoughts about that, given what you have
4 heard today would be useful. We can certainly think about other ways to have your input
5 on that kind of thing.

6 DR. ROTH: I would definitely second Ben's comment. I am in a position
7 now where I don't have a 50 hour a week job anymore. I can devote all kinds of time if I
8 want to. I know other people aren't -- other people have to get back to the office. I
9 would welcome opportunities like that so you are more connected during the six month
10 points.

11 There were a couple things that went on at the last meeting -- I looked at
12 those materials before I looked at the homework for this meeting and went I wonder what
13 happened with that. There were a couple things that I wondered what happened with
14 that. If we are a little bit more in a communication line of some sort of major things that
15 come out. I did get on the blog thing. I have the SAMHSA email announcements. I
16 think a little more to us would be a little more continuity.

17 MS. HYDE: That's helpful as well. Any other comments about this?

18 MS. WOOD: I'm relatively new to anything involved in grant review so I
19 hope my question is not stupid, but I am wondering if we had to physically meet or if
20 those reviews could be done on paper?

21 DR. KOPANON: They're often done over the phone.

22 MS. WOOD: Over the phone? Even beyond that, could it be sent as an
23 assignment to the members without a phone call? Just send it out and they respond back?

1 DR. KOPANON: Yes. Usually the phone calls are five minutes. There is
2 not a lot of discussion.

3 DR. ENOMOTO: I think we are generally under a time pressure to get it
4 done. I think a phone call is the most expedient because we need to make the awards.
5 Waiting for email votes to trickle in would probably be less efficient.

6 MS. HYDE: Part of the -- I've been around lots of advisory committees,
7 who either wanted to or, in this case, had an obligation to look at funding decisions.
8 What it does is it gives them something concrete to do. Some people don't like it because
9 it's like what are you asking of me. Other people feel like that is the thing I feel concrete
10 about. They don't feel very concrete about the advice and discussion. It just seems like
11 discussion.

12 Whereas, the discussion was much more important to me than some sort
13 of blessing of a process, which they don't have the ability to make much change in
14 anyway. Even if they did give us some pretty strong advice about changing the process,
15 there would be rules, regs, and other things that would make it hard for us to do much
16 with anyhow.

17 Anything else about that? I just wanted to get your thoughts about it
18 because you really have morphed a little bit as a group and there are new people around
19 the table. I wanted to get your thoughts about it and maybe get it on your minds as well.
20 If we do come back to this reauthorization issue, we will have to decide whether we are
21 going to take on that issue and if so, how.

22 All right, let's just make one more check to see if we have a public
23 comment. Nothing? You have the public comment. Part of your job is to listen to the

1 public comment. We have it. Maybe that individual will decide he wants to participate
2 in another meeting as well.

3 I think we are at a close, unless there is something else that somebody
4 wants to put on the table. Any of the Centers want anything from the Committee?

5 MS. WOOD: I was just asked to remind you to leave your books on the
6 table. Katie will mail those to you if you want. Ben just reminded me that your expense
7 forms are there. You might want to take that out and take it with you. We would like to
8 get your report within five days so we can reimburse you as quickly as possible. Thank
9 you.

10 DR. ROTH: Are there taxi logistics?

11

12 ***Agenda Item: Closing Remarks and Adjournment***

13 MS. HYDE: I will remind you if you have time and you are interested the
14 STAC is meeting. If you are interested in joining that, you can listen. That group is
15 actually very explicit around tribal leaders, which has made it very hard to keep people
16 on that committee. We have a fairly large number of new people.

17 Having added them to the larger group yesterday, we have gotten lots
18 more input about tribal issues, I think, than that group in my opinion. That group tends to
19 be a little bit isolated about what they are struggling with or dealing with. I think it has
20 been much more effective to have them in the larger group.

21 That is not so much true with the Women's committee. They have been
22 very active and very content-rich of their own, but then their involvement in the larger
23 committee has also raised those issues up, I think. I think the three programmatic groups
24 have been either very focused on things that are happening in their center as well as

1 contributing to the larger group. Each one of them is a little different as well. Hearing
2 nothing else that we need to take care of, thank you very much for your time. We are
3 adjourned.

4 (Whereupon, the meeting adjourned at 1:45 P.M.)

5

6