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Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
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SAMHSA National Advisory Council
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Transcribed by:

Dana A. Cohen

For

Alderson Reporting

1 [On the record, 8:33 a.m.]

2 Chairperson Hyde: Well, we have our things to
3 eat and fruit and candy and coffee and what more could you
4 ask? You've got a list of things you could ask?

5 [Laughter.]

6 Chairperson Hyde: We'll get to that today.

7 Audience Member: World peace.

8 Chairperson Hyde: World peace?

9 Well, we're going to talk about world peace
10 today, when Kathryn presents on the military families. So,
11 trauma and justice, we've got lots of world peace today.

12 Audience Member: [Indiscernible].

13 Chairperson Hyde: Oh, whirled peas? All right,
14 well that's lunch.

15 [Laughter.]

16 Chairperson Hyde: All right, we have about 25
17 people online or helping or watching through the web
18 process, so know that there's more people, then, that are
19 in the room. My job in the first 5 minutes, here, is just
20 to welcome you again, and tell you that I thought
21 yesterday's discussions were very rich and very helpful and
22 I have lots of notes, our great transcribers and folks

1 already gave us some notes from yesterday, some highlights
2 from yesterday, so that's really terrific.

3 Good morning. How are you today?

4 Dr. Amaro: Fine, I'm delighted to be here. I
5 heard yesterday was really terrific.

6 Chairperson Hyde: It was. We're going to let
7 you get settled, there and then we'll have you introduce
8 yourself. And you do have to use the microphones,
9 remember, in order for the people on the Web to hear us,
10 you really have to be at a microphone to talk. And
11 remember that when you're done talking, turning off the
12 microphone is helpful.

13 So, let me just say, again, that I thought
14 yesterday was really, really, really helpful. I thought
15 all of you really came together well as a group, I think we
16 have a great group that have a lot of different
17 perspectives and a lot of different input to provide to us,
18 and it was terrific.

19 What our goal is today is to get through the rest
20 of the four initiatives that are remaining, and then to
21 have a little bit of open dialogue about what -- the paper
22 that Tom and Fay have been working on, and then a little

1 bit of open discussion about other things or what you want
2 to -- sort of the gestalt of the day and a half, if you
3 will, and what that means for you. Because just a
4 reminder, where we are in the process is trying to finish
5 off a paper that has been through about 17 versions, and we
6 are also in the process of Fiscal Year 2012 budgets and --
7 neither of which did we want to finish until we had our
8 meeting with you. So, it will have a very immediate
9 impact, your discussion yesterday and then today will have
10 a very immediate impact in those really critical things
11 that we're doing in the next few weeks that will then come
12 out into the public in due time.

13 So, that's the process, I think that's all I need
14 to say, are there any other announcements we need to do
15 about lunch or logistics, or anything like that, Faye?
16 Toian? I have Faye on the mind.

17 Ms. Vaughn: I think you know that we're having a
18 box lunch today and you've placed your orders -- you placed
19 your orders yesterday so therefore they will be available
20 during the lunch hour.

21 The other thing is that you have your forms at
22 the end of your notebook, and we need you to complete those

1 forms, your honorary forms and take that expense form with
2 you and return it.

3 Besides that, you have a quorum and you can
4 proceed.

5 Chairperson Hyde: Okay, I'll let you get back to
6 your seat and then you're on for two seconds to tell us who
7 you are and what your perspective is that you bring to the
8 council, we did that with everyone yesterday, so we'll give
9 you a chance to do that.

10 Dr. Amaro: My name is Hortensia Amaro. This is
11 my first year on the Council and I am a Professor in Health
12 Sciences and Counseling Psychology at Northeastern
13 University, Associate Dean for Public Health, and also I
14 direct the Institute on Urban Health research where we
15 conduct a lot of studies on substance use and abuse, but
16 also on other issues related to health disparities in
17 social determinants of health.

18 My perspective, I think, really comes from my
19 work in the last 30 years in developing treatment programs
20 for Latina and African-American women, and there is
21 modalities from residential to intensive outpatient and
22 regular outpatient. And in the last five years, we've been

1 doing the same thing in terms of the male population in
2 Boston.

3 I think one of the things that I would like to
4 think more about on this Council is the role of social
5 determinants of health on issues of addiction, treatment,
6 and prevention. Because when people go back to their
7 communities, they're basically faced with all of the same
8 issues they had there that were related to their initiation
9 of drug use. And oftentimes we tend to not pay attention
10 to those.

11 So, I was really happy to see the report that was
12 written, because I think it reflected on those factors --
13 the larger, kind of, upstream factors.

14 Chairperson Hyde: Okay, great. Welcome.

15 Dr. Amaro: Thank you.

16 Chairperson Hyde: I think that everybody else
17 who's here was here yesterday, so I think we're ready to
18 jump in. So, we're going to do military families, first,
19 and we are starting just about on time.

20 So, Kathryn if we can try our best to stay on
21 time, that'd be great, thanks.

22 PRESENTATION OF KATHRYN POWER, M.Ed. DIRECTOR,

1 SAMHSA'S CENTER FOR MENTAL HEALTH SERVICES

2 Ms. Power: I wasn't here yesterday, I'm Kathryn
3 Power, I'm the Director of the Center for Medical Services
4 and I'm delighted to be with you here this morning, and
5 also to say hello to old friends, hello. And to welcome
6 the new members of the Council, and I appreciate the
7 opportunity to talk with you this morning.

8 This particular strategic initiative area is one
9 that has been building over the last several years at
10 SAMHSA, and it came into fruition and came to our attention
11 about 3 years ago when the -- or 3 or 4 years ago -- when
12 our grantee programs began to experience conversations with
13 some of the people who were using our grant programs and
14 identifying themselves as members of the military,
15 directly, or members of the military family.

16 And we began to understand that, even though
17 SAMHSA does not have a direct mission in terms of treating
18 the military or treating the veterans, we were seeing many
19 of these people come into our grant programs and we were
20 beginning to have conversations with them. And so we
21 thought we really needed to stop and think about where we
22 were headed.

1 And so that was really the genesis for us
2 beginning to understand and learn more about military
3 families and what their needs were.

4 A couple of these fast facts that we have put
5 together, here, just to get you thinking about why we're
6 taking a look at this issue, is that we have a very high
7 suicide rate currently going -- being experienced by
8 members of the military, and particularly those individuals
9 who have either been in Vietnam and are of an age where
10 they are at high risk for suicide, or those who are coming
11 back with very serious issues from the Iraq/Afghanistan
12 war.

13 We know that many of the post-deployment and
14 reintegration issues that are experienced by military
15 members are issues -- they are issues like depression and
16 anger and other kinds of behavioral health issues that many
17 of the members of the military and their families have
18 experienced.

19 No one goes to war without experiencing trauma.
20 Whether or not that trauma is easily or moderately or after
21 a difficult struggle incorporated into their experience,
22 man, many members of the military experience trauma and, in

1 fact, move forward and continue to serve nobly. Many
2 people have adjustment issues in terms of dealing with that
3 trauma. We have to face the fact that trauma is a
4 universal experience for the people who have been in
5 combat.

6 We have -- we're beginning to hear about the
7 wives and spouses and children who, in fact, are
8 experiencing their own anxieties and depressions relative
9 to major multiple deployments and the fact is that you have
10 a -- one of the parents who may be deployed for a long
11 period of time and that, in fact, has I think major
12 consequences for the family and for the family altogether.

13 So, one of the things that we began to take a
14 look at under this new strategic initiative is that we
15 wanted to articulate what is it that SAMHSA does? What is
16 it that SAMHSA can do? What is SAMHSA's expertise? And
17 what can we offer this particular population?

18 And so we have really devised a strategic
19 initiative that helps us look at fostering access to
20 evidence-based treatment for military servicemembers and
21 their families. This includes, by the way, all active duty
22 military, Guard members, Reserve members, and veterans and

1 their families. And we are specifically looking at the
2 issues related to mental health, mental illness and
3 substance use conditions.

4 And so one of the things that we are doing,
5 currently, is that we are facilitating relationships with a
6 lot of other Federal agencies with a lot of other partners,
7 and we are trying to engage and discourse with many of the
8 entities -- our grantees, our States -- trying to ensure
9 that the behavioral health needs of military servicemembers
10 are being met appropriately.

11 I think one of the most important things that we
12 need to do is we need to ensure that wherever the military
13 member presents for needs, that they are fully aware of the
14 choices that they have. That is, it is not our intent to
15 serve someone in our service system that is an HHS-funded
16 service system when, in fact, it is appropriate for them --
17 and they choose -- to use services that are offered by the
18 active duty Department of Defense or by the Veterans
19 Administration.

20 And so, part of what we have to do is share our
21 expertise with both DoD and VA, but also be knowledgeable
22 about the kinds of services that military servicemembers

1 can access through DoD and VA, which is a very complicated
2 services. These are closed healthcare systems. And having
3 been a military kid myself, and a military spouse, and a
4 military member, you step into those systems, and you are
5 inside a system. And, consequently, where we have some
6 expertise in delivery of evidence-based practices in
7 community settings, we are conversing with both the
8 Department of Defense and the VA about the kind of
9 outreach, about the kind of practices, about the kind of
10 community-based issues that are important.

11 We're focusing on recovery, we're having an
12 opportunity to share with them what we think are the best
13 practices. And I think that dialogue is really benefiting
14 everyone. It's benefiting the closed systems of the
15 Department of Defense, the Veterans Administration, which
16 is learning to do a lot more outreach and getting beyond
17 their bricks and mortar, and, in fact, it is helping to
18 build, I think, a measurable sense of ownership about all
19 of us paying attention, as a community, to this particular
20 population, not just the designated DoD and VA entities
21 that are supposed to carry about this population, but that
22 all of us are.

1 So, we're doing a number of things here, I'm not
2 going to read all of the goals, but we are focusing in on
3 the provision of appropriate services, when necessary,
4 appropriate technical assistance, appropriate connections
5 and collaborations, we're brokering training and technical
6 assistance across our grantees and particularly across the
7 states.

8 What we're doing in this initiative at this
9 moment, is that we're working with the Federal Interagency
10 Policy Committee, which is a White House policy group that
11 is developing a national strategy to improve the overall
12 readiness of the military and its members and the family
13 members across the behavioral health spectrum over the next
14 10 years. This is a White House initiative that I think is
15 broad, and very far-reaching and specifically is addressing
16 making sure that the behavioral health is given some
17 priority across the health spectrum for our active duty and
18 Reserve and veterans.

19 We're going to conduct our policy academies,
20 we've done this before -- we did 10 States in 2008, we'll
21 do another 10 States this coming June. We bring in State
22 teams that are comprised of the leaders in those States who

1 want to do something about the military family members who
2 are there on active duty or who are coming back as Guard
3 and Reserve members, and it is an opportunity to learn, in
4 a very intense way, over a 3- to 4-day period -- 2- to 3-
5 day period, about how you can structure a State plan that
6 will help you, at the State level, take ownership and
7 provide support services for military family members.

8 The Interagency Policy Council is described,
9 here. Here's the Policy Academy and where we are going in
10 the Policy Academy in the first part of June, and we also
11 have a Federal Partners Reintegration Group that is part of
12 the transformation agenda from several years ago. Now we
13 have a Federal Partners Group co-chaired by the DoD and the
14 VA. And they take a look at specific issues of help for
15 families, strategic collaboration, doing employment
16 opportunities -- a whole variety of agency collaboration at
17 the Federal level, looking at how we can improve the status
18 for military family members.

19 One of the specific things that SAMHSA is working
20 on is a special pilot project. We are -- have a good
21 relationship with the National Guard Bureau, which is the
22 national entity that oversees the State National Guard

1 units, administratively, even though the National Guard
2 units really belong to the Governor at each State. There
3 is an administrative bureau and we have formed a special
4 Memorandum of Understanding with the National Guard Bureau,
5 relative to National Guard members and States being
6 connected with the leadership and the behavioral health
7 entities that might be available in each State.

8 We are in this MOU, devising a unique opportunity
9 to exchange information with the National Guard Bureaus,
10 and we have two States -- both Kansas and New Mexico -- who
11 have stepped forward with their leadership at the National
12 Guard level and their leadership at the behavioral health
13 level to pilot test a particular program that will help us
14 map the locations of where behavioral health providers are,
15 compile an inventory of appropriate training, develop
16 outcome measures so that we can determine what kind of
17 connectivity is occurring between the needs of National
18 Guard members, the National Guard unit at the time, the
19 family needs and making sure that they get into service.
20 So, we are just in the midst of launching this pilot
21 program with these two States, and our hope is that it will
22 go further and further to other States as we refine the

1 methodology.

2 That's my 10 minutes, I'm going to move to
3 questions and answers and recommendations. We're very,
4 very pleased that this particular strategic initiative
5 focuses on this population. We think this population is of
6 enormous concern and interest to America. We think it is
7 time for everyone to step forward and be a part of the
8 community that supports the military family and the veteran
9 and all of their concomitant needs.

10 And, in particular, we feel very strongly that
11 their behavioral health needs are the ones that we really
12 need to focus on. That the issues of their mental health
13 status or substance use are tantamount and really do need
14 to be considered as a part of the overall health assessment
15 for our military.

16 Thank you very much.

17 Chairperson Hyde: So, let me just say a couple
18 of things as we move into -- I'm already getting hands,
19 here -- the dialogue. One is, I forgot to tell you what --
20 maybe you found it, but it's on page 5 of your "Fast Facts"
21 and it's on slide 8 of your -- of the Power Point. And
22 you'll notice under the Power Point that we are, sort of,

1 calling out the homelessness issues which relate to the
2 housing initiative, but it also, obviously, has a direct
3 relationship to substance abuse and mental illness. And
4 then the suicide issue. And the third bullet there -- and
5 prevention, obviously, for the family members -- but the
6 third bullet is a little misleading the way it's written.
7 It's the issue that Kathryn noted, that we're trying to
8 make sure that Tricare has the appropriate access, or is
9 appropriately available to -- for providers to be
10 credentialed, or other kinds of connections so that system
11 -- even closed though it is, will have some input or some
12 service possibilities from the "civilian service system"
13 and also trying to connect up, as Kathryn said, the --
14 those people who don't choose to use those closed systems,
15 but would rather come to one of our service providers, et
16 cetera.

17 The other thing I just want to call out about
18 this one, this is the only one of the ten initiatives that
19 is a population base and so on, you know, we didn't call
20 out tribal members or children or adults or any other kinds
21 of populations -- they are really throughout all ten. And
22 this one -- it is equally true, that old, young, the tribal

1 the -- all of the populations are in this but the -- I
2 think what are we saying, Kathryn? About 10 million
3 individuals falls into either Active, deployed, Guard,
4 veteran or their families? So, it's a large group and it
5 crosses the spectrum of populations out there.

6 All right, so with that, Stephanie, I saw your
7 hand and then we'll go from there.

8 Dr. LeMelle: Good morning.

9 Part of what I was going to say you actually
10 just, I guess, sort of addressed. But, I guess just to
11 bring out further, the issue of women in the military. And
12 I think that the number of women enrolled in the military
13 and the Armed Forces, in general, is much, much higher than
14 it used to be. And I think that oftentimes the structures
15 that were previously put in place for the healthcare of
16 veterans did not focus on women's issues. And I think that
17 now it's, you know, it's something that we really need to
18 be aware of, I think, maybe even carve out a little bit to
19 make sure that it's not overlooked.

20 Chairperson Hyde: Okay, great comment.

21 Hortensia?

22 Dr. Amaro: It's great to see this initiative. I

1 just -- I wanted to also highlight the issue of women in
2 the military and the issue of sexual assault of women by
3 military members while they're in service. And, you know,
4 the -- inadequate ways in which that's being dealt with and
5 silenced. I think it would be great if they could get some
6 training from SAMHSA on some of these issues -- I know it's
7 a sensitive one.

8 The other one was, we did a study in Boston of
9 African-American veterans and their experience in terms of
10 accessing VA as well as other healthcare services. And I
11 think there needs to be some attention in this initiative
12 around the issues of racism and discrimination within the
13 healthcare system, but particularly the VA. We did the
14 study that was funded by the City Health Department in
15 collaboration with a group of African-American vets. And,
16 you know, significant experiences of discrimination within
17 that system of care, and as a result impacting their
18 satisfaction and access to those services.

19 Ms. Power: Is okay for me to comment?

20 Chairperson Hyde: Yes, yes.

21 Ms. Power: I would love to see the study,
22 because I think there are people who would be interested in

1 seeing what you found. And I think that the racial and
2 cultural issues, I think, are important everywhere. No
3 just in the VA, but everywhere in terms of the kinds of
4 disparities that we see, but I think that would be
5 extremely important for us to see the study.

6 And I will tell you that about 16 to 17 to 18
7 percent of the military are female. And we have a
8 tremendous amount of work to do in the area of women in the
9 military. And the Department of Defense Mental Health Task
10 Force Report specifically cited the fact that women have
11 not been well treated, or have been ill treated, in many
12 cases, in terms of the fact that the culture itself is not
13 necessarily embracing of women, never mind that the level
14 of treatment may be different and the level of --
15 particularly the amount of sexual trauma that women have
16 experienced, is a major issue. And one of the things that
17 we think we can bring to this discussion is the
18 understanding of that trauma, and is the appreciation for
19 assessing people appropriately for that trauma which many
20 women in the military do not reveal, and particularly
21 through sensitive assessments and through making sure that
22 both DoD and the VA are involved -- which they are, and

1 they do have specialized programs, but again, many times
2 the women do not necessarily choose to use those services,
3 there. So, we're seeing that a lot of our community-based
4 providers really want to get smarter about how do you
5 interact, culturally, in terms of understanding the
6 military and then looking at the experience of women in the
7 military, as well.

8 We just had a recent Federal partners meeting on
9 Woman and Trauma. And again, because of the
10 administrators' highlighting the trauma strategic
11 initiative, as well as the military family members, we see
12 that there's a tremendous amount of synergy about that
13 sensitivity to what the women have experienced and our
14 ability to be able to intervene and help those women heal
15 in a way that's appropriate. So, I appreciate your
16 comment.

17 Chairperson Hyde: And I do want to encourage
18 both of you to bring this back up when we talk about the
19 Trauma Initiative. One of the things these initiatives
20 have evolved is we see the connection to -- initially when
21 we had the 10, people were asking, "How do they fit
22 together?" And the more we talk about them, it's so clear

1 that they fit. So, please do bring that back up again.

2 And, Hortensia, I'm going to ask you to turn off
3 your mic when you're done, there.

4 So, George, I think I saw your hand next?

5 Mr. Braunstein: I just wanted to state, then,
6 I'm glad to see the traumatic brain injury is part of the
7 planning, because what we're seeing, both with vets and
8 some others, but primarily with vets is that they're coming
9 in, presenting with mental health, substance abuse, but
10 there's a real strong overlay of traumatic brain injury.
11 And unless we plan for those needs, what we end up doing is
12 looking at what, ultimately, becomes treatment failures
13 when we try to use the more traditional models.

14 So, I appreciate that that's there and I hope
15 that it's kind of built -- built into kind of all of the
16 models that go out, is looking for it, designing the kind
17 of programming that needs to go along with it, when it's
18 needed.

19 Chairperson Hyde: Great, thanks George.

20 And we are pleasantly joined by Larry today, so -
21 - he is our Veterans -- Department of Veterans Affairs ex
22 officio rep. So, Larry, why don't you start by just

1 introducing yourself for two minutes, and then go ahead and
2 make your comment?

3 Dr. Lehmann: Yes, thank you very much, I'm Dr.
4 Larry Lehmann from the Department of Veterans Affairs
5 Central Office of Mental Health Services, and my
6 specialized area is in post-deployment issues, Post-
7 Traumatic Stress Disorder and disaster response. And so
8 I've been really pleased and excited to be able to
9 participate with SAMHSA in programs such as the Federal
10 Partners Reintegration work with the Federal Partners
11 Group.

12 And really I want to say, I also would like to
13 see that study, because we do have a lot of capability,
14 there, in causing a lot of focus on women's health issues.
15 And really want to be sure that we are as open as we can be
16 to the issues of women as well as the range of racial and
17 ethnic diversity in our military population. We will have
18 one of our subject-matter experts in women's mental health
19 at the Policy Academy available to respond to any questions
20 that come from the States. I wanted to make that clear,
21 and am extremely pleased to hear that being discussed,
22 here.

1 Sorry I was a bit late, I thought we were
2 starting at 9:00.

3 Chairperson Hyde: We changed it on you, sorry
4 about that.

5 Dr. Lehmann: Sorry.

6 Chairperson Hyde: That's okay.

7 Kathryn, a couple of people, and you have
8 mentioned the Policy Academies. Will you just talk about
9 the June meeting?

10 Ms. Power: The second week in June, I see Eileen
11 in the background -- yes? Second week? Yes. Seven to
12 ninth, and we have 10 more States coming in. We actually
13 has, I guess you could call it a competition -- an invited
14 competition in 2008, where we asked the States if they were
15 interested in doing something about planned approaches and
16 planned strategies for returning servicemembers in their
17 States, would they be interested in putting together a very
18 short application, and we had a lot of response, as you can
19 imagine. And at that time we chose 9 States and Guam,
20 correct? Pardon me?

21 Voice: Puerto Rico.

22 Chairperson Hyde: Just remember that people on

1 the Web can't hear that, you need to repeat.

2 Ms. Power: So, we had 10 groups come in and they
3 choose the leadership that they want to have, we make some
4 suggestions for their single-State authority for substance
5 abuse, Mental Health Commissioner, Medicaid Director,
6 Governor's Office, you know, other people that would have a
7 role. And at that time, in 2008, basically we were looking
8 at a behavioral health response and had not engaged as many
9 active duty military entities as we could have and we
10 generally, also, encouraged the Guard and the Reserve
11 Components to also be a part of the team.

12 The team comes in, there's generally eight to ten
13 people that the State chooses, and they spend a very
14 intense two and a half days in a facilitated dialogue
15 amongst themselves with experts that come in and talk to
16 them about what's the latest in substance abuse prevention,
17 what's the latest in recovery-supported services, what's
18 the latest in trauma-informed care? What's the latest
19 evidence-based practice in employment services who cannot
20 find a job in terms of their military experience? So, we
21 get them talking about all of the aspects of the work that
22 they want to do for their community. And every State is

1 different, as you can imagine. Some States have a large
2 percentage of active duty installations, some of them have
3 very large National Guard units, some of them don't have
4 any active duty installations but have Guard units, some of
5 them have Reserve components that are not connected with
6 any outstanding large DoD facility and they're kind of
7 scattered. Some of them are in rural areas, some of them
8 are American Indian tribe participants who don't get
9 connected, some of them live in areas that are far away
10 from VA facilities, so you have all kinds of different
11 experiences, given the States.

12 So, it was very popular, all of those entities
13 went back, created strategic plans, and have really taken
14 off, and have really done some tremendously important work
15 with bringing in specific DoD and VA programs, making the
16 connections between DoD and VA and behavioral health,
17 providing cultural military 101 training to lots of folks,
18 about how do you talk about the military and why do you
19 have to know about the military.

20 And then also cultivating an awareness across our
21 grantees and across behavioral health providers that, in
22 fact, this population is coming, and that this population

1 will be at your door, and that this population will have
2 needs, particularly the wounds like TBI and PTSD and severe
3 depression and trauma-related experiences.

4 So, we're doing it again, and we're doing it
5 again with another 10 States. Two of the States are
6 returnees who are coming back as faculty so we can kind of
7 have a train the trainer opportunity. And we're with --
8 now with those ten States, really getting the majority of
9 those geographic locations. We're a high percentage of
10 both active duty, Guard and Reserve individuals are
11 stationed. So, we're very excited about it. And it's
12 going to be, I think, an opportunity to, once again, look
13 at the state of the art in terms of what DoD is doing, what
14 VA is doing, what community providers are doing, and bring
15 to bear prevention and treatment in a way that, I think, is
16 really wonderful. And it's a great chance for States to
17 show ownership of this issue.

18 Chairperson Hyde: Okay, Arturo, I think I had
19 you next.

20 Mr. Gonzales: Kathryn, I was wondering, what
21 groups are you working with in New Mexico, besides the
22 Guard? In your MOU?

1 Ms. Power: We have a number of groups, I don't
2 have the list in front of me, but I can get you the list.
3 We have all of them on a phone call for -- we just had a
4 phone call this week relative to the veterans' group, some
5 of the -- the Yellow Ribbon campaign folks, the community
6 mental health centers, the substance abuse agencies, the
7 Governor's Office, the National Guard Office and a host of
8 other 501(c)(3) private, not-for-profit folks that are on
9 the call. They're creating an advisory committee in New
10 Mexico and they're doing the mapping about our -- our
11 mapping capacity is being used to identify the behavioral
12 health agencies -- I have a list, Arturo, that I can give
13 you.

14 Mr. Gonzales: Is this kind of like an outgrowth
15 of that initial initiative that took place from the
16 Governor's Office and the Veterans Administration where
17 they focused on a couple of counties?

18 Ms. Power: Yes.

19 Mr. Gonzales: Okay.

20 Ms. Power: Yes. And I think we're trying to
21 connect all of those because many of the States had things
22 moving forward anyway, and they've been doing a lot of work

1 over the last several years. So, this is connecting the
2 dots with some of the smaller activity that might have been
3 occurring in one place in the State, with other activity
4 over here and that other providers have gotten together to
5 do training, and we're trying to connect that with some of
6 the cultural training that goes on through the Guard, we're
7 trying to connect it with the Yellow Ribbon campaign, we're
8 trying to connect those things, or help facilitate those
9 things in States, and many of the States have been doing
10 this for a number of years. It's not that this is new.
11 But we're trying to get it more coordinated, and facilitate
12 the coordination at the State level.

13 Mr. Gonzales: Great.

14 Chairperson Hyde: Arturo, I can tell you -- and
15 you probably know this -- but for the rest of the group, in
16 New Mexico, the uniqueness was there was private sector
17 involvement and tribal involvement, as well as VA
18 involvement, which was really cool, with States. Because
19 that usually doesn't connect up with community providers,
20 and so it was a unique kind of thing.

21 Okay, who else, let's see, I've got Judy next.
22 And then, by the way, just for the Council to know, Terry

1 Cross is on the phone, welcome Terry.

2 Ms. Cushing: Kathryn, can you tell us what
3 States are going to be involved in the June policy panel?
4 Or, Policy Academy, excuse me?

5 Ms. Power: I can. But not at this moment.

6 [Laughter.]

7 Chairperson Hyde: Why don't we let her get that
8 and we'll come back. We've got other people on the list.

9 Ms. Power: I will get those States for you and I
10 -- we've been doing all of these site visits and I will get
11 that list for you.

12 Chairperson Hyde: Cynthia, you're next.

13 Ms. Wainscott: For the new council members, I
14 think Pam actually talked about this yesterday, briefly,
15 but Kathryn didn't mention that that Federal Partners Group
16 would not exist were it not for SAMHSA. Their leadership
17 has made it happen, and they continue to lead it.

18 And also, you don't know, I don't think, that
19 Kathryn is in the United States Naval Reserve, and that
20 gives her a position of both authority and -- she's talking
21 to her peers when she talks to them. So, that's just
22 important part of the success that has occurred, I think,

1 and wanted to make that public.

2 The thing that I've been thinking about since you
3 talked, Kathryn, is a conversation we had yesterday which
4 was about prevention, and how reimbursement for prevention
5 is what makes it happen. This may be a place where we
6 could move that forward. Because the Department of Defense
7 is very, very concerned about this issue. My daughter,
8 today, and her entire family -- including her children --
9 are doing a mental health assessment before they go
10 overseas. Her husband, who has been in combat recently,
11 herself and her child. They care about the mental health
12 of these families because of what has been occurred and is
13 projected to occur.

14 So, it may be a place we can push the
15 reimbursement for prevention to a new place, and get some
16 real outcomes, because we know what's happening now, and we
17 should be able to prevent it through proven interventions.

18 Chairperson Hyde: Okay, great. I don't have
19 anybody else on the list. Does anybody else have a
20 comment? Judy, do you want to go again?

21 Ms. Cushing: It was on a different subject, I
22 didn't know if that was all right.

1 I had a question about the pilot project and
2 interested in how that will be rolled out in replication of
3 that project around the country.

4 Ms. Power: The pilot project is in -- probably
5 in its, maybe, third or fourth month at this point, Judy.
6 And the two States have really done a lot of bringing
7 together the disparate groups who might have an interest in
8 terms of serving the population. And they also have to
9 ground themselves in an understanding about what DoD and VA
10 services are already available, and that takes awhile for
11 people to just understand what kind of access, where people
12 are located, and getting familiar with all of the
13 opportunities that are available.

14 We hope that -- we're going to give this about 6
15 months, so we're halfway into the 6 months of looking at
16 how we can replicate this. And since both of these States
17 are unique, and both of these States have different
18 profiles, we think that we'll have a good set of two -- you
19 know, these two States will be unique enough that we can
20 apply some of the methods.

21 What we had to do initially was we had to do the
22 mapping on the system that would identify current providers

1 -- that took some time. You can imagine that you have to
2 sort of get our computer program to take a look across the
3 State, crosswalk it with what the State has, and so that in
4 and of itself took some initial planning time. So, if we
5 can plug that in, we figure we'll go to a next level of,
6 perhaps, another 6 or 7 States, and we'll try that, and see
7 where that might bring us.

8 And some of those States we may get from the
9 Policy Academies, who may want to just move out,
10 immediately, and do it on their own, without any
11 facilitation from us. And there -- then our plan would be
12 to hopefully bring it to scale to those States that are
13 interested in doing it. You really have to have a Guard in
14 place, a National Guard unit that's will to do this, you
15 have to have a Guard that's willing to talk to Reserve
16 component members -- that's an interesting, you know,
17 process, because you have to have a National Guard unit
18 that knows how to outreach to component parts of DoD
19 Reserve units, and be willing to do that.

20 You have to have a set of community providers
21 that are willing to be -- to take the risk, frankly, in
22 terms of saying, "Yes, we are ready and willing and able to

1 open our doors to this population, and we want to." And
2 so, you have to have a number of things in play.

3 But, I think everyone is so convinced that now is
4 the time to address this population -- now -- so that they
5 don't go for years and years and years without having
6 appropriate supports that we think that the States are
7 really -- as I think Pam indicated -- at a critical point
8 of leadership, and then at the local level, engendering the
9 kind of responsibility and engendering the kind of cultural
10 adaptation that's necessary for the population.

11 So, we're hoping that we can bring this to scale
12 with those States that are interested, over the next year.

13 Chairperson Hyde: Any follow-up?

14 Ms. Cushing: Yes. If National -- if, in States
15 where there aren't military bases, so the National Guard
16 and Reserve are the main population, and they're very
17 robust and have reintegration projects that are very --
18 functioning a very high level, should they contact -- who
19 in your office or at SAMHSA should they contact if they
20 aren't involved in this -- in your efforts, yet?

21 Ms. Power: Definitely, they should contact me.

22 Ms. Cushing: Okay.

1 Ms. Power: Okay? Because I think that we'll
2 start to gather the names of the States that have an
3 interest and that want to position themselves. Some of
4 them will come naturally out of the Policy Academy
5 experiences, and some of them will just proclaim that
6 they're interested in doing it.

7 The ten States, are you ready? The ten States
8 for this Policy Academy are: Alabama, Arizona, California,
9 Maine, New Jersey, North Carolina -- who was a 2008
10 graduate, North Carolina is a tremendously large military
11 State, they are a graduate of the 2008 program, and they
12 will be back -- Ohio, Puerto Rico, Tennessee and Washington
13 State was also a 2008 graduate, and they're coming back,
14 okay?

15 Chairperson Hyde: So, Terry Cross is on the
16 phone, I understand, Terry, you have a question or a
17 comment?

18 Mr. Cross: Yes, I just wanted to reinforce the
19 comment about prevention, and particularly, one of our
20 concerns in the country is to the family issues. We have a
21 particularly large number of women serving, and the history
22 of intergenerational trauma and grief, this -- the

1 circumstances here, I think really indicate we need to pay
2 attention to what is going on with the children, so I think
3 the child/adolescent family branch could have a role in
4 this regard.

5 Chairperson Hyde: Terrific, thank you, Terry.

6 Let me just make a quick comment and then I see
7 another hand or two.

8 I came to SAMHSA -- this is one of the ten
9 initiatives that I came to SAMHSA thinking we should focus
10 on. And I've actually been very pleasantly surprised to
11 know all of the work that's already gone on and that was
12 terrific. I think I came to this, in part, because of my
13 experience in New Mexico and the work that we did there,
14 but just in part between the connect between the sort of
15 range of population -- from very young children needing
16 prevention help and families needing that kind of
17 assistance -- all the way up to fairly severe substance
18 abuse and mental illness as a result of military
19 experience, or co-curring with military experience whether,
20 whichever, then results in folks in our delivery systems or
21 on our streets or whatever.

22 So, this population issue gives us an opportunity

1 to look at everything -- from prevention to major
2 supportive-type services to basic treatment and service
3 access to stigma issues which may not be specifically
4 because of the military, but just -- it gives us an
5 opportunity to address, literally, all of those issues.
6 Which is why, I think that this population is one of our
7 focuses, is the only as a population focus gives us so much
8 opportunity, both in terms of systems development, service
9 development, prevention and the whole shtick. And it's --
10 we tend to think of military as the person who is actually
11 in the Service or in the Guard, but there's so much going
12 on with spouses, with kids, with elders that have
13 caregivers leaving and all of that kind of stuff, so it's
14 just a huge, huge issue.

15 Arturo, I saw your hand again?

16 Mr. Gonzales: Yeah.

17 I just wanted to ask, Kathryn, these, for
18 example, the pilot programs or the Academies -- are they
19 funded -- a multiyear funded kind of situation or are they
20 one-year things? The reason I'm asking is some States are
21 going to have elections -- gubernatorial elections, and how
22 do you continue to maintain, you know, if things change or

1 Administrations change in the State, how do you maintain
2 the efforts that have been initiated by you under new
3 Administrations or whatever, so that you don't lose the
4 momentum?

5 Ms. Power: The miracle of the military
6 initiatives is that we have no appropriation for it and we
7 have -- and the fact that we're doing this and we have no
8 appropriation for it is a miracle.

9 And the way we do that is by using money that has
10 been identified from the Center for Mental Health Services
11 and its recycle opportunity. So, when we have certain
12 programs that come to an end or we're moving them forward
13 every year, we have, in fact, been able to identify funds
14 in the Center for Mental Health Services to do the Policy
15 Academy. So, that's how we're doing that.

16 The Pilot Program is really done without any
17 funds. It is basically a collaborative goodwill process
18 that we're using staff here at SAMHSA to help do the
19 mapping project and to help do the coordination, and to
20 help do the phone calls, and to help do all of that. And
21 the States are putting in what they believe is appropriate
22 in terms of staff time. So, these things are all being

1 done with no appropriations, literally, but that we are
2 building, I think, an opportunity for investments to be
3 made over time. I think that's the approach, is that we
4 think that certainly we want the VA and the DoD to be a
5 partner with us. And in the last Policy Academy they
6 helped support it, this particular policy academy they are
7 a part of the planning, but they are not necessarily giving
8 us any money at this point.

9 But the reality is that we hope that in building
10 this initiative, we want investments to be made by
11 community providers, by States, by a lot of entities, a lot
12 of Federal entities to focus in on this population. And I
13 believe, over time, that will be the case. But that's how
14 we're doing it right now.

15 Chairperson Hyde: This is a good example,
16 Arturo, of the roles issue we went over yesterday, is that
17 funding things is not all that SAMHSA can do. And we've
18 been trying to build on some of that.

19 It's also been very gratifying for me, actually,
20 to meet with Kathryn with Veterans Affairs folks and the
21 DoD folks and National Guard folks, and Rick Broderick, of
22 course, you know, has been very interested in this area, as

1 well, in meeting with us, too -- they've all been very
2 interested in expanding the efforts, whether it's the MOU
3 or whether it's just the discussions around service models
4 and other kinds of approaches.

5 So, is there anybody else who wants to comment
6 about this one?

7 Yeah, Flo?

8 Ms. Stein: Thank you. I want to thank SAMHSA
9 and particularly Kathryn for her leadership on this issue.
10 It's an issue that works very well for advocacy in States,
11 so if people want to do something to help the military and
12 their families and some communities have had a hard time
13 figuring out what to do, and SAMHSA's leadership has really
14 helped.

15 I mentioned yesterday and I said I would mention
16 it today, I really appreciate the goal on there to look at
17 the Medicare regs and the Tricare regs that limit who
18 providers can be, as we need more providers particularly in
19 some communities than right now, Tricare will enroll. And
20 we still have a shortage of Tricare providers.

21 And then we have a new population emerging in our
22 State that we're working on, that -- our highest suicide

1 rate is in young National Guard members who have never been
2 deployed, and therefore they don't have any benefits,
3 nothing is activated for them and their suicide rate has
4 exceeded the national average. So, it's like a whole new
5 problem that's sort of in our lap that we're looking for
6 solutions. So, any of the suicide initiatives also cross
7 over into this area.

8 Chairperson Hyde: Absolutely, and Kathryn, I
9 don't know if you want to comment about that, but clearly,
10 even though we had suicide in the prevention initiative, we
11 have it here, as well, because the numbers are beginning to
12 be staggering.

13 So, Kathryn, you want to comment about that?

14 Ms. Power: I do. And I think that one of the
15 things that the Department of Defense and the National
16 Guard are particularly concerned about are the numbers of
17 people who are both attempting and completing suicide who
18 have never been deployed. And that seems to be a
19 tremendous issue, as you so cited, Flo, and I think part of
20 what we're doing, obviously, is we're supporting an NIMH
21 and their work on the research. Richard McCann from my
22 staff is a part of the work that they're doing in terms of

1 looking at causes, et cetera, and doing some pretty
2 significant research on that level.

3 And also, we're learning more and more about what
4 interventions actually work, in terms of some of the
5 outreach program that we're doing on our suicide prevention
6 lifeline and I think it's just tremendous that we have the
7 opportunity to do this, and hopefully we'll learn from
8 that, about better and better and better intervention so
9 that we can address this issue.

10 Chairperson Hyde: Okay, I'm ready to move on
11 unless anybody else has got a burning comment on this one?
12 Let me remind you, this is one of the three top initiatives
13 that the Secretary is looking to SAMHSA specifically to
14 perform and lead on, prevention being the other one and
15 trauma which we will hear about later today, being the
16 other.

17 So, thanks Kathryn. I think you're on again for
18 housing and homelessness. And the materials here are on
19 page 8 of your fax sheet and, let's see, slide --

20 Ms. Power: This strategic initiative --

21 Chairperson Hyde: -- slide 19. I'm sorry.

22 PRESENTATION OF KATHRYN POWER, M.Ed. DIRECTOR,

1 SAMHSA'S CENTER FOR MENTAL HEALTH SERVICES

2 Ms. Power: -- is on housing and homelessness.
3 And I think it's important, the way that this is entitled,
4 because I think the focus needs to be on providing housing
5 in terms of eliminate homelessness. I think that's why we
6 frame it this way. That we really want to pay attention to
7 housing as a goal, so that we can eradicate homelessness.
8 And I think that, even though we are not a housing agency,
9 or a housing authority, we absolutely, positively, want to
10 focus in on making sure that individuals have homes and
11 that, in fact, homelessness can be prevented. And I think
12 that ties in nicely with a host of the other strategic
13 initiatives, and we clearly know that this is a problem,
14 that in fact, every night in America it's estimated that
15 there are over 700,000 individuals who are homeless. We
16 think that that number is underestimated in terms of the
17 numbers of people, particularly since we have been going
18 through a period of economic distress, and we're concerned
19 that the numbers of people has -- have grown and that, in
20 fact, more and more families are homeless, not just
21 individual adults, but more and more families.

22 We know that the homeless population, there are

1 estimates in terms of the numbers, or percentages that have
2 mental illnesses or substance use disorders. Depending on
3 which study you look at, those estimates vary tremendously,
4 but overall, I know certainly in my State of Rhode Island,
5 when we look at the homeless population and we survey them,
6 up to 30 percent had serious mental illnesses. There are
7 other studies that show anywhere between 20 and 30 percent
8 have serious mental illnesses. Sixty-four percent, we --
9 have been found to have an alcohol or substance use
10 disorder, and most importantly, the fact is that these are
11 not the only disorders they have. There are other health
12 conditions that are seriously impacted by this -- in this
13 population.

14 And one of the things that's of great concern, I
15 think, to all of us, particularly at HHS, is that these
16 individuals, of course, use resources in the community that
17 do not necessarily help them at any particular point in
18 time, they only help them with an acute problem, like in
19 the emergency room, where they help them with an acute
20 problem in the healthcare system, but don't necessarily
21 address the larger issue.

22 And so this notion about chronic homelessness has

1 really captured the attention of many of the individuals in
2 HHS over the past several years, and I think we are trying
3 to focus in on all of the population, not just individuals
4 who are chronically homeless, but also individuals who are
5 experiencing homelessness on a more acute level. They are
6 often not enrolled in Medicaid, and do not have access to
7 healthcare and, of course, many of the women who become
8 homeless become that way because of high rates of abuse and
9 depression and, in fact, domestic violence and other kinds
10 of issues.

11 So, we know the issue is very powerful, very
12 real, and very tangible and we want to address it just as
13 surely as we can.

14 We know that the solutions for homelessness
15 include a host of supportive services and a host of direct
16 services. Generally, people become homeless because they
17 can no longer afford their home -- they've either lost
18 their home or they've lost their job. We know that in
19 order to address homelessness, we want to see solutions
20 like employment, affordable housing, better access to work
21 and income supports.

22 One of the things that we'll talk about in this

1 strategic initiative is known as permanent supportive
2 housing. The notion that we need to have a goal that
3 basically states that we seek, for the people we serve,
4 permanent supported housing. And I think of that term is
5 an important one. It's a use of a particular set of key
6 words and phrases that are important, not only in the
7 housing community, but in the behavioral health community.
8 We want to be sure we improve housing stability, we want to
9 reduce the number of days of homelessness, and we want to,
10 certainly, see a reduction concomitantly in the community
11 with the under use of the transitional kinds of services
12 that people often fall into -- literally, the jails and the
13 inpatient settings.

14 We have a portfolio, unlike the military
15 families, in which we don't have a current portfolio other
16 than our strategic activity. We do have a portfolio of
17 programs that we have within SAMHSA, we have the PATH
18 Program which is projects for assistance from transition
19 from homelessness, which is a formula grant program that
20 goes through the States to local community providers. We
21 have the Services in Supported Housing Program, we have
22 general homelessness and Services in Supported Housing in

1 both centers, both in CMHS and the Center for Substance
2 Abuse Treatment. We have a program called SOAR, which is
3 SSI/SSDI outreach, access, and recovery. A very important
4 connection program if you are -- if you can become eligible
5 for Medicaid, that gives you the gateway, frankly, to
6 healthcare services and to other kinds of services. And,
7 if you can become eligible for SSI and SSDI, that is your
8 gateway into Medicare and Medicaid. And then we have
9 Homeless Technical Assistance Center.

10 So, you see, we have a portfolio of homelessness
11 which, by the way, is also true of many other agencies
12 across HHS. There is a -- Congress has really allocated a
13 homelessness portfolio across several of the agencies and,
14 in a concerted and interagency effort to address
15 homelessness, our mission for this strategic initiative is
16 to increase the availability of stable, affordable, and
17 permanent housing options for individuals who are homeless
18 due to mental illnesses or substance abuse by providing
19 supportive services, necessary for obtaining and retaining
20 permanent housing. So, we want to make sure that not only
21 people have housing, but that they have the appropriate
22 services so that they can stay in the housing, and not

1 necessarily move from place to place to place to place to
2 place to place, But that we are creating this goal of
3 stability so that, in turn, will help the stability of
4 treating their mental illnesses and substance use
5 disorders. So, if you can have stability in your living
6 situation, so much better that that will engender stability
7 in your healthcare situation.

8 So, some of the things we're working on besides
9 the portfolio, the portfolio continues to move and we have
10 grant programs, et cetera, in terms of both the formula and
11 the discretionary programs, we are doing specific steps in
12 this initiative of partnership building across HHS,
13 particularly with ASPE, which is the Assistant Secretary
14 for Planning and Evaluation, the Center for Medicaid and
15 Medicare Services, and also other Federal partners like
16 HUD, Housing and Urban Development.

17 So, there's a large collaborative effort going on
18 across the Obama Administration where HHS and HUD are
19 really working together in a particular fashion around
20 collaboration with Section 8 vouchers and building health
21 and social service support at the same time with the
22 voucher program, so that there will, hopefully, be a

1 seamless approach across the Federal agency with States and
2 with individuals so that we can move people into permanent
3 supported housing, they will be supported with housing
4 vouchers, they will be supported with Medicaid in terms of
5 their health services, and they'll be supported with SAMHSA
6 funds with other kinds of supportive services that are not
7 funded by Medicaid.

8 We also have just, finally, developed and got to
9 final form the Supported Housing Toolkit, and so we're
10 getting that out in the hands of the country, the grantees,
11 the States, et cetera, it's an excellent toolkit on
12 supportive housing services

13 We also work with the Interagency Council on
14 Homelessness and that is a vast Federal representative
15 group across the Federal agencies on -- that are,
16 obviously, focusing on their programs, now working in a
17 much more collaborative fashion to make sure that we're
18 focusing and not duplicating, but complementing each
19 other's efforts. And we're going to be expanding SOAR as
20 an initiative, to make sure that people understand how
21 quickly they can get entitlements if it's properly done.
22 The SOAR program has really been very successful -- many

1 States and grantees have used it to get people eligible for
2 SSI in a much more rapid fashion.

3 We're also continuing to do a variety of
4 collaborations with Federal partners. We're working with
5 CMS on the 1915c home and community-based waiver services
6 so that we can segue that kind of usage of States using the
7 Medicaid's so that we can galvanize the use of those waivers
8 for permanent supportive housing. We're collaborating with
9 both HRSA, the Health Resources and Services
10 Administration, and with the Department of Labor. So,
11 there's a lot of activity going on, collaborating with ACF,
12 the Administration for Children and Families, to make sure
13 that we are working together to, again, ensure that there
14 is more permanent housing for individuals in their runaway
15 and homeless youth program, and also just outreaching and
16 connecting with the numbers of advocacy organizations that
17 are moving forward on this very important issue.

18 The Federal Government has a tremendously long
19 history of trying to focus and address the needs of
20 individuals. I think what is unique about this particular
21 time and place for this effort is that this Administration
22 has said, "We really want people to have homes and jobs and

1 there will be a coordinated effort to make those things
2 work together so that we can, in fact, provide permanent
3 housing, provide supportive services, and hopefully help
4 people get jobs.

5 So, thank you very much.

6 Chairperson Hyde: Before I open this one to the
7 floor, let me just say a couple of things. One is, the
8 project that Kathryn referred to in the Fiscal Year 2011
9 budget, it is in the President's budget, it is very
10 explicitly trying to make sure that HUD and HHS and both
11 the Secretaries of those two Departments are very committed
12 to this. Put housing voucher dollars on the table so you
13 can pay for the housing, Medicaid dollars on the table so
14 that they -- people can get their basic health and
15 behavioral healthcare through that. And then SAMHSA's role
16 is to put other services that cannot be funded through
17 Medicaid, but that are required to support someone in that
18 housing to really, I would say test -- but we already know
19 this works -- to prove or to show or demonstrate, whatever
20 the right word is, that we really can move people from
21 chronic homelessness into permanent and supportive housing.
22 And, the focus, again, is on people with serious mental

1 illness and/or substance abuse disorders. So, that's
2 critical.

3 There may be a couple of other things I'll throw
4 in here, but let me open it to the floor.

5 Oh, Kate -- the fact that Kate is the first one
6 that wants to talk reminds me of the other thing, which is,
7 this is a population that is going to be very impacted
8 positively by health reform. This is a lot of the under
9 133 percent folks who have not had access to healthcare, so
10 Medicaid's going to have them.

11 Kate?

12 Ms. Aurelius: And we're glad to have them.

13 What services, specifically, is SAMHSA funding
14 that need to be there that Medicaid's not and what work can
15 we do to get Medicaid to cover them?

16 Ms. Power: We have a list of those services that
17 are funded by Medicaid and those that are not. Many of
18 them are related to specific client-tenant kinds of
19 negotiations, some of them related to employment services -
20 - I can share the list with you is fairly extensive. And a
21 lot of the services are funded by Medicaid, and so there's
22 actually very few that are not Medicaid. But, generally,

1 they relate to negotiations with a tenant and client kinds
2 of collaborations, that is, is there a negotiation
3 necessary or a mediation necessary, that kind of service,
4 and then a whole host of services related to employment.
5 So, I can get you that list, Kate.

6 Chairperson Hyde: I think this is one area
7 where, if the behavioral health world had the same kind of
8 1915c waivers, or other -- 1115 waivers -- that, say, the
9 DD population does, or other kinds of populations do, we
10 could have them in Medicaid. It's the -- and the work that
11 John is doing with CMS around 1915i waivers is, I think,
12 part of what we're trying to test a little bit with CMS
13 about that.

14 Ms. Power: Well, and healthcare reform makes
15 those waivers, now, a State-plan option. So, you don't
16 necessarily have to get a waiver which, if you're a State,
17 is a lot easier.

18 Chairperson Hyde: Yeah, that's great. And I
19 think someone like yourself who sort of understands about
20 these roles, if you've got thoughts about this, it's one of
21 the things we may try to test in this initiative is, how
22 much is left out that a person really needs that we can't

1 get covered through a health approach.

2 Ms. Power: If I could add, if there are other
3 services -- when I give you this list -- if there are other
4 services that are not on the list that you think SAMHSA
5 should support, we'd like to know that. Because I think
6 that we want to be thinking about those things, because we
7 have some flexibility about the SAMHSA funds that are
8 specifically different than what CMS will fund.

9 Ms. Aurelius: Well, and I would encourage us to
10 push those back to CMS, frankly. And to look at that list
11 and say, "Why aren't they?" You know, what's different
12 about HCBS services for the elderly, or developmentally
13 disabled, that aren't reasonable coverable for people with
14 serious mental illness.

15 Chairperson Hyde: I think the big issue,
16 frankly, is the waiver issue and that -- which obviously
17 stems from the IMD issue. And I'm not arguing for the IMD
18 to go away -- don't take that wrong -- but that's -- those
19 home and community-based waiver services that people with
20 serious mental illness don't -- or substance use disorders
21 -- don't get access to have, in part, to do with that
22 mechanism, not with the -- they tend to be, you know, an

1 optional service. So, it's left up to each State to make
2 that determination.

3 But that's part of what John is working on, as
4 well, so --

5 Mr. Cross: Pam, this is Terry --

6 Chairperson Hyde: Terry, let's let you go ahead,
7 I know this is hard for you, but we're trying to queue the
8 discussion. So, we got into a little dialogue, there,
9 which is a good thing, but I want to make sure everybody
10 has an opportunity. So, Terry, you go next, and then we'll
11 go to Hortensia.

12 Mr. Cross: Okay, I just wanted to jump in and
13 mention the opportunities with the TANF emergency funds
14 under the ARRA legislation in this area. And also to
15 commend SAMHSA for its partnership with ACF on this issue
16 and I just don't think we've looked at TANF in the past as
17 the partner for people with serious mental illness and --
18 or families, for that matter -- and the flexibility
19 available, currently, with the emergency funds, the
20 timeline is very short, although Congress may extend it for
21 another year. But it certainly points us to, maybe, some
22 longer-term partnerships between TANF and SAMHSA,

1 particularly in the systems of care work.

2 Chairperson Hyde: Terrific. Yeah. Great idea.
3 Carmen and I are meeting, I think it's maybe even yet this
4 week, to just talk about a lot of areas. Carmen is head of
5 the Administration for Children and Families about a/lo
6 issues that we can collaborate on together. So, that's
7 good input.

8 Hortensia?

9 Dr. Amaro: Kathryn, thank you for that report.
10 That collaboration with HUD and Section 8 vouchers is so
11 critical.

12 Let me tell you about an experience we had where
13 we got some set-aside, sort of, Section 8 vouchers from our
14 Housing Development Department in Boston to try to avoid
15 women, after they've been in residential treatment going
16 into sort of transitional, and you know, back to shelters.
17 And, what happened is that we had the vouchers but we could
18 not identify the housing, it took a long time ago.

19 So, the issue in some areas, and I'm sure this
20 differs on cities, is really the lack of housing,
21 especially in inner-city areas. And, related to that
22 which, I would encourage you to think about, is the problem

1 of local zoning laws that restrict the lot size and the
2 building of multiple housing units. It's been a strategy
3 that's really, either intentionally or not, resulted in
4 great racial segregation, it's a really major factor that
5 has contributed to that.

6 And it really impacts the availability of housing
7 for the families that we serve. So, I think, you know,
8 city planners and State planners around local housing laws
9 are really -- zoning laws -- it's really critical because
10 you could have, I mean, it's our experience, we have the
11 vouchers in our hands, and we still are having a hard time
12 getting the women into permanent housing, because of the
13 problem with the shortage of the housing staff.

14 Chairperson Hyde: This is a great comment,
15 because our pilot is just trying to pilot one aspect of the
16 larger housing issue. But, certainly, the number of units
17 and where they are, and whether they exist and whether
18 they're accessible -- accessible not in a physical sense,
19 but in a policy sense --

20 Dr. Amaro: Right.

21 Chairperson Hyde: --are things we're talking to
22 HUD about. We actually have -- are in the process of

1 commissioning a paper that will, sort of, lay out for all
2 of these issues, because there's work going on in some
3 places that we don't have anything to do with, like the
4 production of units -- but if the units don't exist, or
5 there's policy barriers to those units, then that's
6 difficult, as well.

7 So, HUD's very interested in working with us on
8 sort of figuring out the whole range of policy, financial,
9 programmatic barriers.

10 Dr. Amaro: Right, and I think working with
11 local, you know, municipalities around zoning laws is going
12 to be critical.

13 If you're interested, there are people at the
14 Institute who do research on the issue of zoning policies
15 and segregation and so, you know, I'm happy to let them
16 know.

17 The other thing I wanted, just, to highlight
18 that, you know, I'm sure this is not new to you, but that
19 the big -- another big obstacle in terms of housing for
20 people who have been in treatment or, you know, who are
21 homeless, have a history of criminal justice involvement or
22 substance abuse that some public housing actually have

1 policies that don't allow those people back. And that's a
2 big barrier, and a real problem for continued, you know,
3 recovery and stability.

4 Chairperson Hyde: We know. And it has arisen
5 over the years, here, at SAMHSA, and our concern about it,
6 and I think we now have a group of people across the policy
7 spectrum that will be able to converse about that. And I
8 think that the notion is that we -- we don't want people to
9 be denied housing simply because of their health status,
10 and I think it's an important issue, and I think in
11 particular, this initiative gives us an opportunity to have
12 that conversation.

13 Chairperson Hyde: George? Oh, I'm sorry. Well,
14 George, go ahead and Marvin's next.

15 Mr. Braunstein: I think that -- I'm really
16 interested to see what the toolkit that might get developed
17 will look like. In Fairfax, what we ended up finally
18 realizing is that we needed to get all of the players at
19 the table planning at the same time about how housing was
20 distributed for folks who were homeless or in precarious
21 housing. And that to make sure that we've also costed out
22 and planned for the supports, the services -- that they

1 were funded and they are -- that we had access to
2 entitlement workers who could put them on to the kind of
3 entitlements that they were eligible for.

4 Because what was happening -- and I think it
5 happens in a lot of systems, is that the distribution of
6 the housing resource, the distribution of the service
7 resource and so forth, all of the different elements that
8 need to be there, are not necessarily planned out together.
9 So, what happens is, you'll get HUD saying, "Well, we sent
10 out these vouchers and they're not being used, or there's
11 housing that's available and nobody's using it," and
12 there's a variety of different reasons for those
13 breakdowns.

14 We, essentially, created -- because the County is
15 -- even the County leaders have made a commitment to house
16 in the next 10 years, at least 50 percent of those people
17 that have been identified as homeless or precariously
18 housed, that they -- we have a blueprint group of leaders
19 who have to create the whole package on an annual basis, to
20 make sure that, the whole piece.

21 So, if what we did there, or what we're doing --
22 it's not a past tense -- would be useful in designing the

1 toolkit, we'd be glad to share.

2 Chairperson Hyde: I think this toolkit is the
3 one that's already available, right? So, maybe we'll just
4 make sure you get access to that and see if you think
5 something's missing.

6 Marvin?

7 Mr. Alexander: I just wanted to comment about
8 the nature of gentrification in most American cities, and
9 just kind of the issue that that's causing when people are
10 asked or forced, depending on who you are, how you look at
11 the situation, to move outside of areas that they are
12 familiar with and move into different areas of cities, or
13 different areas of the county, that they are not typically
14 in. But that gentrification -- I don't know if it's a
15 shortage of housing, of course that's one issue. But, I
16 think, affordability, and I know that's something that's
17 come up, you know, it's, there are vouchers and there's
18 things to meet that issue. But if people aren't
19 comfortable in their environments that they're kind of
20 forced to live in just because they can't afford where they
21 used to live, I think, you know, that -- that's definitely
22 something to look at.

1 And also, I'm so happy that, you know, shelter
2 hadn't come up, and that we're actually talking about homes
3 for people and not shelters. And I want to pay particular
4 attention to young people in shelters, and young people who
5 aren't necessarily homeless, but may become homeless by
6 choice. They may run away, and, you know, typically
7 they'll go to, or go west, or go to Portland, or go to
8 Phoenix, or they'll go places like that, so particular
9 geographic locations where young people typically migrate
10 when they decide they want to become homeless.

11 Chairperson Hyde: Thanks, Marvin.

12 Stephanie?

13 Dr. LeMelle: To the point of housing stability,
14 if people are fortunate enough to have housing, often they
15 lose it during crisis times for them, and crisis being
16 either inpatient hospitalizations, extended
17 hospitalizations, or going into the criminal justice
18 system. And what we see in New York, often, is that people
19 lose their benefits, because they're not renewing, they're
20 not filling out the forms, they're not going to
21 appointments. And if there was a way -- in the same way we
22 sort of discussed before -- of having a service to

1 intervene at those points -- and there's no funding for
2 that, there's no real funding stream for that particular
3 role -- but at those crucial crisis points, if there were
4 some way of funding a service to look into that, when
5 someone is being hospitalized or going into the criminal
6 justice system, to ensure that they don't lose their
7 benefits, because when they lose their benefits, then they
8 lose their housing. Or, the rent's not paid for 2 months
9 and they lose their housing. So, those are sort of the
10 crucial points towards stability.

11 Ms. Power: One of the initiatives of the SOAR
12 Program is to do that. And as we're expanding the SOAR
13 Program, we're finding that the local providers and the
14 local consumers and family groups are seeing that very
15 issue. It is the transition, when they're moving from one
16 place to another, or having a crisis, or having a
17 particular experience. And particularly as they go into
18 the criminal justice system, they're -- we're, you know,
19 we're -- now the SOAR training is going to be able to
20 inject that level of benefit -- analysis and benefit
21 assessment into the workforce that's already there,
22 hopefully, in both the community health center or the

1 community mental health center or the substance abuse
2 agency or the criminal justice setting or wherever, and we
3 hope that that expansion on the SOAR training will get at
4 that very issue. Because I think you're absolutely
5 correct, and if we can make that a part of the normal
6 process, for people to have that kind of benefit analysis
7 and assessment as they transition, so much better.

8 Dr. LeMelle: Is there a way that that would
9 actually be funded? Is that something that people could
10 bill for?

11 Ms. Power: That is part of our -- our program,
12 will be to expand the SOAR training under our homeless
13 portfolio, yes.

14 Chairperson Hyde: Stephanie, you do raise a good
15 issue about, sort of, along the line Kate did, is you could
16 argue that some level of case management could get paid
17 for, up to a point. But at the point they actually fall
18 off the benefit, then the case management gets harder to
19 pay for.

20 I think Ed had his hand up next, and then back to
21 Kate.

22 Dr. Wang: You know, this area -- when I listen

1 to Kathryn's talk and so forth, it's, you know, this is the
2 one that I think, even though it's not one of the top
3 priorities, but I think it's still critical -- I think that
4 SAMHSA really gets it, in terms of the supportive nature.
5 And this is, I think, what SAMHSA can actually export, you
6 know, to other Federal agencies -- HUD, ACF, and so forth,
7 in terms of what our expertise is about.

8 You know, permanent supportive housing, I think
9 it's absolutely, absolutely, the goal for our people, you
10 know, homeless individuals in the U.S. and families, as
11 well. You know, I'm thinking about, you know, when I was
12 trained as a psychologist, you know, Mazlo would talk
13 about, you know, the basic needs. The bottom one is
14 actually about housing and food, about shelters. It is not
15 about, you know, self-actualization, it is not about, you
16 know, treatment and so forth.

17 But, with that in mind, I'm still thinking about,
18 you know, I guess we are being trained now to wave this
19 around about the four models --

20 [Laughter.]

21 Dr. Wang: -- if you look at, you know, what we
22 focus on in terms of homelessness, it's exactly what we

1 talk about -- prevention works, treatment is effective, and
2 if you look at it, behavioral health is essential to health
3 for homeless individuals, because they have very poor
4 healthcare as well as behavioral healthcare, and people do
5 recover. People can when we maximize their potential, they
6 can get -- when they have a shelter, with a permanent home,
7 they can excel. And then, you know, the rest of the
8 supportive services that we can export in terms of our
9 expertise.

10 The one thing that I do want to say, though, is
11 that -- you mentioned earlier about -- and Martha mentioned
12 two -- specifically about youth, as well as young adults
13 and families. I think that there's an increase of
14 homeless, or at-risk of homeless for youth and young
15 adults. You know, when I was in Portland, I was, you know,
16 really aghast by, just, coming from the airport -- young
17 people. You know, and I don't know whether they're
18 homeless or not. But, you know, I don't want to
19 stereotype, but there seems to be a lot of them.

20 So, my advice is that -- if this is not already
21 done, you may already have done it -- is go and actually
22 getting input from the so-called shelters. There are

1 programs in Boston, for instance, and I know that other
2 States have -- specifically focused in terms of, you know,
3 young adults, as well as youth, for those that are homeless
4 or at risk of homelessness. It's a very, again, it's a
5 very different culture. I talked to some of them -- they
6 are not going to go into the traditional system, the
7 traditional shelters.

8 So, if there's a way to get that input from, you
9 know, these agencies, I think that would be a great
10 direction for us to go.

11 Chairperson Hyde: Okay, great.

12 Kate, and then Marvin.

13 Ms. Aurelius: So, there's some significant CMS
14 policies that are driven by statute that will impair these
15 processes, and Pam, you talked about IMDs being one of
16 those. There's also -- if you become incarcerated, you are
17 no longer Medicaid eligible, it's just the law. So, is
18 there any hope in these conversations that the Executive
19 Branch could provide some feedback to the Legislative
20 Branch of government to say, "You know, we understand that
21 you don't want to spend money twice on the same thing, and
22 we think that there's ways around that, that you've created

1 this -- the incarceration one, particularly, you have a
2 serious mental illness, you engage in some behavior in the
3 community that gets you locked up, you lose your benefits
4 right there." Well, then the jail system can't get you
5 out, there's a bunch of resource on both ends of that
6 trying to keep you out and trying to get you out, but it's
7 -- we need to try and rethink that, so that there's easier
8 ways to keep people's benefits in place so that they can go
9 back to their homes. And it's better for everyone, it's
10 cheaper, it's more cost-effective, so --

11 Chairperson Hyde: Kate, this issue came up when
12 we talked with DOJ, because they had been meeting with some
13 criminal justice folks who were kvetching about this issue.
14 And, obviously, part of it is Congressional issues, but
15 part of it is also the difficulty in getting data systems
16 to suspend eligibility, for example, because you have to
17 know what's going on in every county jail system in the
18 country to do it.

19 Do you have any -- have you -- have you who deal
20 with Medicaid folks thought about any sort of operational
21 issues to fix this?

22 Ms. Aurelius: We're piloting, right now, a daily

1 data exchange with our second-largest County of pop -- you
2 know, so that -- and to put people in a suspend status as
3 opposed to a complete disenrolled status. You can only
4 leave people in a suspend status for so long before CMS
5 thinks that that's fraud, so you have to be careful about,
6 you know, so we're kind of drawing the line at 6 months,
7 thinking that's really a jail stay as opposed to a prison
8 stay, and we're going to see how that goes and try and
9 expand it, because it does help on the discharge --
10 discharge isn't the right work -- what do you do? Thank
11 you, when you get out of jail -- to make release easier and
12 back into the community and right back into supportive
13 services. Because there's not, you know, behavioral health
14 systems are not getting paid to go to the jail, and hang
15 out, and do the service planning to get people ready to get
16 out and the hospital -- or, the jail is really wanting to
17 shoot people out.

18 So, yeah, we're trying some of the data exchange
19 pieces, but it's very painful. And the thing we ran into,
20 there's -- I know there's only 15 counties and ten, you
21 know, one Department of Corrections. And when Medicaid
22 comes to talk to the jail people, it's like, "Who are you?"

1 You're the County person? What's the difference between
2 you and the correctional system?" It's, you know, when
3 you're coming at it from a healthcare, you don't even know
4 who the Justice people are.

5 Chairperson Hyde: Thanks, Marvin?

6 Mr. Alexander: I always wonder, how does
7 Medicaid know when someone goes to the County jail?
8 Especially if it's, you know, so -- I -- audit?

9 I just wanted to make a different, a comment just
10 about what Ed said. I just wonder how we were defining
11 homelessness, because there are people who, they may have a
12 shelter, they may be with Grandma, or a family that lives
13 with Grandma and Great-Grandma, or whatever, multi-family
14 homes versus kind of -- and they are -- they're homeless.
15 Families that don't have their own home versus someone that
16 we see on the street that may be experiencing psychosis.
17 So, what's the definition of homelessness and have we
18 included those other populations as being kind of serious
19 mental illness?

20 Ms. Power: I think for purposes of the
21 initiative, we're looking at individuals who are in need of
22 permanent supportive housing, who may have behavioral

1 health issues. So, from our perspective, we're concerned
2 about -- the status could be very different.

3 We just had an interesting conversation with the
4 Government Accounting Office who came in and wanted a
5 definition of what we meant by homeless and they talked to
6 every agency across HHS and everyone had a different
7 definition.

8 So, for us, from the strategic initiative
9 standpoint, we care about people with mental illnesses and
10 substance abuse disorders and we want to address the issues
11 of people who are in -- whatever status they may be in or
12 whatever their experience, if they are in need of permanent
13 supported housing and they have those conditions, that's
14 what we want to address.

15 Mr. Alexander: So, this could include single mom
16 with schizophrenia that lives with her mother?

17 Ms. Power: That's correct.

18 Mr. Alexander: Okay.

19 Chairperson Hyde: Okay, Judy?

20 Ms. Cushing: Following up on both Marvin's
21 comments and Ed's, we're told that, on any given day in
22 Portland, there are 1,000 young people -- homeless youth --

1 on the streets. And we're also told that Portland and a
2 couple of other cities are magnets for young people,
3 because they find a friendly environment for homeless young
4 people. Wouldn't it be interesting if there was a way to
5 capture the data of these young people, person-to-person?
6 And I am asking this question because we're actually
7 carrying out a project, a peer-to-peer survey, prevention
8 project in Portland in three high schools where peers are
9 interviewing and surveying their own peers over lunch and
10 after school on PDAs, and the data we're capturing is
11 unbelievable. It's real-time data, and it's designed to
12 catch, you know, to try to be as accurate as possible.
13 But, how interesting it might be.

14 Many of these young people, as Marvin said, are
15 absolutely homeless. And I find it interesting that, in
16 Portland, we're very, very fortunate to have huge support
17 from SAMHSA programs for homeless -- programs for adults
18 that are groundbreaking work, thanks to SAMHSA's support --
19 for adults and veterans -- but not for youth.

20 So, it's just a question as to how we can capture
21 information from this population that we don't know a whole
22 lot about.

1 Ms. Power: Actually, we'll take that two ways,
2 one is the social media comment -- again, Steven, the young
3 man who's going to be working with other staff in SAMHSA on
4 this issue, had to leave for just an hour this morning, but
5 I'll make sure that he gets that comment. And then on the
6 youth issue, I just want to highlight that the Interagency
7 Council on Homelessness -- I always want to say to end
8 homelessness, but it's just homelessness, right? Has youth
9 called out as one of the populations they want to identify
10 -- it's veterans, it's families, youth, and chronic home --
11 people with chronic -- people who are chronically homeless.
12 I think those are the four groups, is that right? Families
13 -- did I say families?

14 Chairperson Hyde: Yes.

15 Ms. Power: Yeah, okay. And that report -- their
16 report is supposed to be coming out, soon. Sometime in the
17 next, literally, few weeks. So, there will be some
18 strategies in that, and Kathryn's been serving as our rep
19 to the rep who's on that group.

20 Ms. Power: And I think one of the things that I
21 see happening is that because of our -- because I think of
22 the spirit of collaboration that's going on, I think you'll

1 see as the Administrator meets with ACF, you know, we'll
2 think about some other ways that we can be complementary.
3 Because their programs specifically are designed for that
4 population. What are we doing in terms of our systems of
5 care work with ACF programs, et cetera? And if we can come
6 to a policy agreement and sort of a practical and tactical
7 way to go after this, I would think that the opportunities
8 for that kind of effort to address that population will
9 grow right now, because of the emphasis that's being placed
10 across the collaboration.

11 Chairperson Hyde: I'm seeing lots of
12 opportunities to link initiatives, and that's fun.

13 Yesterday we talked to Mark, I think you were out
14 of the room, Pam, sort of in detail about the opportunity
15 to link with community partners and the way the old DART
16 campaign did, to promote the message -- the wonderful
17 messages -- that are on the front of our handout. And as I
18 got away from that discussion I started thinking, "Duh, we
19 have an obvious constituency to market SAMHSA to," which is
20 the second part of what Mark talked about doing, that's the
21 mental health planning and advisory councils.

22 And we are so proud of what has happened in

1 Georgia with SOAR. We went from about a two-year -- two-
2 year -- application process, to two months. Charlie Bliss
3 comes and brags about it all of the time, I am not, in any
4 way, in my mind, connected SAMHSA to that.

5 So, one of the things we could do, as part of
6 thinking back to Mark's discussion yesterday, is some five-
7 minute CDs that we send out to each planning and advisory
8 council that brags on SOAR and has our name attached to it.
9 There's many opportunities like that. But, so, if we can
10 use the successes like this which are rolling out in the
11 States to market ourselves to the public mental health
12 system in that way, that could be very impactful.

13 Chairperson Hyde: Great, thanks.

14 Let's see, Flo?

15 Ms. Stein: I just wanted to say for future,
16 working together, our Medicaid agency was required by the
17 legislature to craft an IT solution for suspensions, the
18 session before last, so there may be some collaboration
19 that could be done.

20 Chairperson Hyde: Okay, that one is so hard to
21 me, because having been responsible for Medicaid for
22 awhile, it's like the operational issues are almost as --

1 they are huge. And it's, sometimes, I think, sometimes,
2 frankly, Medicaid agencies get put into the you're, "You
3 don't want to help," mode when this one really is a
4 difficult operational issue, quite aside from the
5 Congressional policy issue.

6 All right, anybody else want to comment about
7 homelessness? Housing? I do want to make sure, because we
8 have, I think, tried to talk about both mental illness and
9 substance use disorders, but I want to make sure that we
10 are approaching this for both of those populations -- all
11 of those populations -- and we're approaching it as making
12 sure that we have housing that is supportive and permanent
13 for anyone who is experiencing chronic homelessness because
14 of those disorders. And, at the same time, we are making a
15 distinction between residential treatment, which we
16 understand is a different issue, and between -- I wouldn't
17 say making a distinction, but we're also trying to
18 acknowledge that people may have different types of
19 supportive housing needs based on their own situation. So,
20 whether that is housing that is dry or not able to have
21 alcohol and drugs in it or any other kind of approach that
22 may be specific to a person's particular situation -- so we

1 want to be sensitive to all of those issues and trying to
2 sort through that as we go through this process.

3 Any final comments on this one?

4 [No response.]

5 Chairperson Hyde: Okay, if not, we're doing
6 really well, we're going to take a 15-minute break and we
7 will start up again at just before 20 after the hour, and
8 we'll hear the two final initiatives.

9 [Recess.]

10 Chairperson Hyde: Okay, these have been great
11 discussions.

12 We are joined by yet another wonderful person at
13 SAMHSA, Larke Huang, who leads our final two initiatives,
14 Trauma and Justice and Jobs and the Economy. We're going
15 to start with Trauma and Justice, the information is on
16 page 4 of your fax sheet and on slide 8 -- no, I'm sorry,
17 slide 7 of the Power Point. Let me remind you that Trauma
18 and Justice is the third of the top three priorities that
19 we've heard about that are part of SAMHSA's responsibility
20 to the HHS strategic planning process, and you've already
21 hear trauma and justice talked about several times in
22 several contexts, so there's lots of overlap.

1 So, Larke, take it away.

2 PRESENTATION OF LARKE HUANG, PH.D., SENIOR
3 ADVISOR TO THE ADMINISTRATOR ON CHILDREN

4 Dr. Huang: Okay, thanks, Pam.

5 Okay, good morning, everyone, it's great to be
6 here. And I have the privilege and the honor and the work
7 of leading two of Pam's initiatives, and it's very exciting
8 how we're organizing our work, here. So, I'm going to --
9 OUR initiatives, your initiatives, now, too.

10 So, I'm going to speak to you first about the
11 Trauma and Justice, what's our strategic initiative number
12 three. And I have more slides than I'm going to go
13 through, but some of those are just background data for
14 you, so I'm not going to read through these, but the first
15 couple of slides are really just some of the fast facts,
16 just pointing out, you know, why we are looking at this,
17 and why we're looking at trauma as an underlie to a lot of
18 our mental health and addiction issues and disorders.

19 But, just to highlight a few, more than 60
20 percent of youth have been exposed to violence within the
21 past year. From our own NSDUH data, one of four adolescent
22 girls engaged in violent behavior in the past year. Youth

1 who engage in violent behavior are more likely -- two to
2 three times more likely -- to use drugs or alcohol. We
3 have a tremendous cost of intimate partner violence, if
4 you've -- from this area, we've had some really egregious
5 cases, recently, of intimate partner violence. And we also
6 look at seclusion restraint within this strategic
7 initiative, as well, and we have estimates of a Harvard
8 risk analysis of about 150 estimated deaths per year due to
9 seclusion and restraint use in treatment settings.

10 We also are informed by the Adverse Childhood
11 Experiences study, which was the first study of a non-
12 clinical population to really look at the association
13 between trauma experiences in childhood with both health
14 and behavioral health outcomes in adulthood. We know that
15 in terms of returning vets -- and probably Kathryn spoke to
16 you about this -- that there is high rates of PTSD
17 diagnosed, we also see among returning vets, high rates of
18 people of color, so we see them carrying several burdens.

19 And then we also are looking at historical
20 trauma, or larger community and group trauma, much of what
21 we associated with diverse racial communities, but
22 particularly Native American populations.

1 More sobering facts -- and this is really
2 focusing on, because within this initiative we're also
3 looking at justice, and what occurs in the juvenile and
4 criminal justice system. We also have for you, here, some
5 of the rates of people with mental illnesses or addiction
6 disorders that are incarcerated or involved in some way
7 with the criminal or juvenile justice system. And I'm not
8 going to read those, and probably many of you are familiar
9 with that, that we often see that as a de facto mental
10 health or substance abuse system for many of our
11 population.

12 The next set of graphs really are from the
13 Adverse Childhood Experiences study, which really underlies
14 the antecedents or the association between these childhood
15 experiences of trauma, which is defined as physical or
16 sexual trauma, having living with a parent who's
17 incarcerated, living with a parent who has a substance
18 disorder or a mental health disorder, and what that
19 predicts in terms of other adulthood diseases, physical and
20 mental health. So, you can see here, when you get -- and
21 these were just counted up by ACE scores. There were ten
22 possible indices of trauma and this is really looking at,

1 not even the severity or the frequency, but just if you
2 have that in your childhood history, how it relates to
3 chronic depression. So that, the more ACE scores, the
4 higher percentage of a lifetime history of depression.

5 Similarly, the higher the ACE scores, they seem
6 to underlie suicide attempts, as well.

7 In terms of smoking, more -- the higher the ACE
8 scores, the greater the chance you're going to be a smoker.
9 And we also know that, for smoking cessation interventions,
10 the higher your ACE scores, if you hit above a certain
11 level, those interventions are not going to be effective
12 with you. So, it also helps us think about when do our
13 interventions for things like obesity prevention and
14 tobacco cessation, how can they be connected with trauma,
15 because that helps us know which programs may or may not be
16 effective for which people.

17 Also, the association with alcoholism with
18 impaired worker performance -- these are, I think, all in
19 your handouts, so I'm going quickly.

20 And then we know that in terms of orally -- early
21 mortality, that those people who live with four ACEs or
22 more, will not live to 65.

1 Okay, so that's just some background information
2 and how we're looking at trauma as a critical piece of our
3 work, here. And we have been doing work around trauma, and
4 I just pulled out, here, some of our grant programs that,
5 in some way, address trauma. Our Safe Schools, Healthy
6 Students has a major focus on prevention of youth violence,
7 and particularly youth violence in schools. Our Child
8 Traumatic Stress Initiative has been probably one of the
9 key initiatives that has helped us in our terms of our
10 knowledge about trauma and knowledge about trauma in
11 multiple sectors of children and families' lives. Our
12 grant program, alternative to seclusion and restraint, as
13 looking at how can we prevent coercive care in treatment
14 facilities. Our jail diversion and trauma recovery is
15 looking at how can we better understand the trauma
16 histories of people who are involved in the criminal
17 justice systems, but also divert people out of the criminal
18 and juvenile justice system into trauma and recovery
19 systems.

20 Our crisis counseling program is focused on
21 trauma after natural or man-made disasters, and then we
22 also have a couple of key contracts that also focus on

1 trauma. Our Disaster Technical Assistance Center, our
2 National Center for Trauma-Informed Care, our National
3 Center of Substance Abuse and Child Welfare, and then I've
4 just listed a few other of our grant programs or
5 initiatives that may not be specifically driven by
6 trauma, or focused on trauma, but also have trauma
7 components and address trauma elements in their work.
8 And that's a pregnant, post-partum women in treatment
9 program, our children's mental health initiative and our
10 adolescent substance abuse treatment programs.

11 Okay, so we actually have a number of efforts
12 going on at SAMHSA, there -- and I should say that many
13 of these efforts also inform other Federal efforts. So,
14 for example, much of our work in the Child Trauma
15 Network is being transported or exported to
16 Administration of Children, Youth and Families for their
17 child abuse prevention grants. Granted, many youth in
18 children welfare have, and foster care, have histories of
19 trauma, so we prepared a toolkit on trauma for their child
20 abuse intake workers.

21 So, we've done a lot of, I think, really
22 significant work, here. It hasn't just stayed within

1 SAMHSA but has been moved out into other service sectors,
2 as well.

3 Okay, but we wanted to think now -- now, sort of,
4 looking at how can we pull this information together, and
5 how can we leverage the knowledge we've generated through
6 our initiatives and our programs, and what might be some
7 kinds of organizing questions for us to think about. So,
8 this is what we've come up with, and we're certainly very
9 open to your feedback and are these the right questions, is
10 this the way to think about organizing our work?

11 So, some of the questions that we came up with
12 is, is what can SAMHSA do to prevent the occurrence of, and
13 exposure to, trauma for family in communities? Some of our
14 programs are really looking at, how can we address
15 community violence? How can we reduce community violence?
16 Certainly our Safe Schools, Healthy Students program has a
17 major effort towards that. So, how can we -- framing this
18 question -- what can we do to prevent occurrence and
19 exposure?

20 Secondly, how can we decrease the number of
21 children, women, and girls experiencing exposure to trauma
22 and violence? Given what I just showed you about the

1 Adverse Childhood Experiences, how can we get in front of
2 that and do some of that prevention, so we don't have those
3 longer, later lifespan sequellae to that.

4 How can we reduce the physical and behavioral
5 impact of trauma? Again, we're increasingly aware that
6 trauma underlies mental health and addiction disorders, so
7 this is very much right in our bailey wick, how can we
8 begin to reduce this.

9 Fourth question, how can we work with criminal
10 and juvenile justice system to divert youth and adults with
11 mental and substance abuse disorders into treatment and
12 recovery?

13 And then fifth, how can we ensure that service
14 systems and supports that are providing services -- whether
15 the prevention or the intervention treatment and recovery
16 are not, themselves, retraumatizing to the people that
17 we're serving in those systems.

18 Okay, so each of those kind of became targets for
19 our kind of fluid workgroup, we're still kind of pulling it
20 together. And we're sort of taking those as goals, and
21 what I've listed, there, is opportunities to think about --
22 and certainly to be informed by your thinking -- but if we

1 look at that first goal, how can we prevent the occurrence
2 of, and exposure to, trauma for families in communities,
3 what are some of our opportunities? Well, sort of,
4 leverage the knowledge that we've gained from each one of
5 our centers, initiatives and activities, does it make sense
6 to implement a national education and awareness effort to
7 better define and measure what we mean by individual,
8 family and community trauma. Some of our work has focused
9 on interventions that are more clinical interventions, but
10 we need to think, what can we do, also, in terms of
11 community-level trauma? What might be some data points
12 that we can actually develop in some of our national
13 surveys, our program evaluations and our GPRA measures, so
14 that we can actually track, so we can benchmark and track
15 our work, systematically, across our programs in terms of
16 trauma?

17 How can we, also, begin to communicate the
18 centrality of trauma to behavior health disorders, okay?
19 That it's not put aside as yet another issue to address,
20 but as an underlying antecedent of many of the behavioral
21 health problems we see.

22 How can we infuse trauma education, knowledge,

1 and tools into our own prevention and health promotion
2 activities, both our own and our sister Federal agencies?
3 For example, as we look at prevention for impaired
4 communities, how might trauma be an issue that's addressed
5 in those? As we look at some of our family and community
6 strengthening initiatives, as we look at some of what we're
7 getting out of health reform, we are named on the home
8 visiting provision in the health reform legislation, and so
9 we've been able to get substance use addressed in that.
10 But, given that trauma, for many of the home visiting
11 population, trauma histories among the recipients of home
12 visitation have significant trauma histories. How can we
13 also get that into the new grant programs that will be
14 going out to States around home visiting?

15 Target two, decreasing the number of children,
16 women, and girls experiencing and exposed to trauma
17 violence. How can we begin to intervene early with
18 families at risk to reduce levels of child maltreatment?
19 And again, what kind of education, training and TA on
20 gender-specific, trauma interventions on our current
21 programs and other Federal interagency work can we do to
22 help us address this goal?

1 Reducing the physical and behavioral health
2 impact of trauma, opportunities -- again, we can -- how can
3 we better disseminate, train, and provide TA on the
4 effective approaches, whether they're the screening, the
5 early intervention and the treatment of trauma that we have
6 learned through our trauma work, whether it's in our
7 trauma-informed care center, or it's our Child Traumatic
8 Stress Network, we have learned a tremendous amount. And
9 in that particular network, there are work groups that are
10 focusing on trauma and justice -- trauma among homeless
11 children and families, trauma in the child welfare, how do
12 we get trauma into the TANF system?

13 So, we have work going on there, how can we
14 better -- get better spread and kind of a multiplier effect
15 on the investments we've made in that area?

16 How can we identify participants in our other
17 SAMHSA programs with trauma histories to better meet those
18 needs? So, again, within our own programs, how we're
19 connecting across our centers and across our programs, so
20 that we can inform better in terms of our drug programs and
21 our PPW programs, and things of that sort.

22 Target number four, this is working with the

1 criminal and juvenile justice system to divert youth and
2 adults, opportunities, here, again to look at trauma,
3 mental health, substance abuse disorders, and treatment
4 using mechanisms such as our problem-solving courts. How
5 can -- whether they're drug courts, mental health courts,
6 domestic violence, other problem-solving courts, how can we
7 introduce trauma screening on a regular basis, and trauma
8 interventions and working with recovery around trauma into
9 those particular systems.

10 How do we improve the availability of trauma-
11 informed care in criminal and juvenile justice systems?
12 And I know that some of our programs have done pretty
13 incredible work in jails and have had the opportunity to
14 actually visit some jails, small jails in Dorchester County
15 here in Maryland, and the L.A. County Jail, toured by
16 Sheriff Bacca to show us what he is doing in terms of
17 mental health and substance abuse treatment and needing
18 significant help around that particular issue.

19 Also, working with first responders to respond
20 more appropriately to people with substance abuse and
21 mental health problems. We have supported a Crisis
22 Intervention Team effort, the CIT program, among first

1 responders and law enforcement, and we need to think about
2 how can we move that out further and get more widespread
3 uptake around that so that our folks that are in a mental
4 health crisis don't need to go the incarceration route.

5 And then, how can we provide community service to
6 support reentry on the back end, offender reentry, into the
7 community to prevent recidivism? We sometimes know that if
8 their trauma histories aren't addressed, this tends to add
9 to the recycling in and out of the criminal justice system.

10 And then, finally, how do we ensure that
11 services, systems and support are not re-traumatizing? We
12 have developed trauma-informed models of trauma-informed
13 care. How do we begin to export these to multiple service
14 sectors, get these into provider training and technical
15 assistance, how can we expand efforts on preventing and
16 reducing the use of seclusion restraint to multiple
17 sectors? I think we've had good outreach in our mental
18 health facilities, some outreach in substance abuse
19 treatment facilities, we've had requests from schools to
20 how can we address this issue in schools and the kids, the
21 children in schools who are most frequently restrained or
22 secluded are our population of children, with behavioral

1 health issues.

2 We know there is pending legislation around that,
3 they've called us to ask about what are effective models
4 around that, and that we can partner with other agencies at
5 the Federal level, where these practices are particularly
6 prevalent and particularly problematic.

7 So, questions to think about, I think that's
8 about my 10 minutes, questions to think about, how can we
9 maximize the benefits from our multiple trauma-related
10 efforts? And really leverage our knowledge and investments
11 in trauma? We're increasingly talking, here, about how do
12 we get a multiplier effect off of our investments, so how
13 can we do that with what we've invested in terms of trauma?

14 We are moving -- and you probably heard this in
15 some of the previous discussions, we are moving more
16 increasingly within our own thinking, and within this
17 Administration, and across Departments to look at place-
18 based initiatives. We're on a number of different work
19 groups, whether that's with Housing and Urban Development
20 or Department of Education and their recently released RFA
21 on promised neighborhoods or HUD's on choice neighborhoods
22 or the White House initiative on neighborhood

1 revitalization -- the idea of looking at places and
2 infusing resources in a very coordinated way to address a
3 host of social issues and problems, there.

4 We're also trying to look at, can we do that with
5 trauma being a central organizing feature, given that
6 trauma contributes to behavioral health issues, to health -
7 - broader health issues. Contributes to the kids that we
8 see that have significant serious mental health issues, and
9 that also are the kids that have the highest dropout rates
10 in schools. So, it's of a concern to education, as well.

11 So, we think, can we convene kind of a
12 consultative session on place-based initiatives, with
13 trauma as a central feature? And this is more thinking
14 about can we go out in the public health kind of approach,
15 looking at prevention, looking at early intervention around
16 trauma, looking at special populations that are
17 particularly vulnerable to trauma and not just big trauma,
18 the big Trauma with a T, like the natural disasters, but
19 those traumas that happen in communities every day that are
20 -- children are subjected to or witness to the drive-by
21 shootings that happen in certain urban neighborhoods on a
22 regular basis that maybe not get the major attention that

1 the big disaster traumas get.

2 And what programs within and external to SAMHSA
3 can we think of to connect with, and to grade, and to -- in
4 terms of a trauma organized broader initiative.

5 Okay, so that's it.

6 Chairperson Hyde: Thanks, Larke.

7 Let me just ask you a question because it's come
8 up in other areas, and I hope this is not throwing you for
9 a loop, but there's a couple of populations --

10 Dr. Huang: You always throw me for a loop, Pam,
11 so I'm used to it.

12 Chairperson Hyde: Well, here's another one,
13 then.

14 [Laughter.]

15 Chairperson Hyde: The issue of the sort of
16 universal nature, if I can use that, of trauma among
17 certain populations, like people who have gone into combat,
18 or children in the welfare system. And that's come up in a
19 couple of different areas, so I don't know if you have any
20 comments about that, but I just wanted to tell you that
21 that -- trauma has come up in a couple of the other
22 conversations in that regard where, by definition, the

1 populations that I just mentioned are --

2 Dr. Huang: I think that would definitely be part
3 of the populations we would want to look at in terms of
4 trauma initiative, given that those people often have
5 histories of trauma, and current lived experiences of
6 trauma. So, how we can intervene quickly and early and
7 consistently with them, I think, would be a key part of
8 this initiative, as well.

9 Chairperson Hyde: Okay, thanks.

10 Marvin, and then Hortensia, and then Arturo?

11 Mr. Alexander: Again, I think you picked a good
12 person to lead up this initiative in Larke.

13 Chairperson Hyde: We picked good people for all
14 of them, don't you think, Marvin?

15 Mr. Alexander: Well, there's a few --

16 [Laughter.]

17 Mr. Alexander: -- trauma in --

18 Dr. Huang: Thanks, Marvin, I like to hear that.

19 Mr. Alexander: But, I also -- I just want to --
20 through systems of care, and I just think this is one
21 opportunity for SAMHSA to take something from a grantee
22 community that they produce -- Idaho System of Care

1 produced a pocket guide for police officers to use when
2 they encounter young people who have mental health issues.
3 In my community and many communities, that continues to be
4 a big issue. How the front line, police officer on the
5 street, how they engage young people, how do they engage
6 families, how do they engage communities of color. And I
7 think that's why we see that minority youth are more likely
8 to be arrested than diverted to treatment.

9 I would like to see that pocket guide reproduced
10 by SAMHSA and encounter some initiative put behind, maybe
11 training police officers around the country, I know the
12 Federation of Families have started to do some of that
13 training, but they need to be more responsive. They need
14 to understand what to look for, in fact, we depend on them
15 to be more responsive. I depend on them to, when they come
16 to my community, to kind of have the same respect for the
17 young people in my community that they would have for other
18 people elsewhere.

19 And I think there's some historical trauma in
20 these encounters that we need to take into consideration,
21 especially when we're talking about certain populations.
22 Particularly, I'm thinking now, you know, the Hispanic

1 population that have this issue, the particular issues in
2 Arizona, my friends in Arizona, they're not happy right
3 now, and also some historical stuff even with African-
4 American families, you know, just the history of certain
5 laws in certain geographical locations, certain areas of
6 our country that attitudes still exist and it continues to
7 perpetuate issues. And I think that trauma -- we need to
8 figure out ways, and I guess through program and we have,
9 but we need to continue to be cognizant of those attitudes,
10 especially with those helping, serving professions like
11 police officers or like social workers or like teachers,
12 the attitude shift.

13 We do a lot of technical stuff, you know? We
14 want to put money to budge and all of that -- that's great,
15 we need to do it. But, I think SAMHSA has been a leader
16 and we need to continue to be a leader and facilitate in
17 that adaptive change, really changing the way people think,
18 and how they approach their work.

19 Dr. Huang: Do we respond back?

20 Chairperson Hyde: If you want to, we're going to
21 be going back and forth a little bit.

22 Dr. Huang: Okay.

1 I think those are great points, Marvin. On the
2 CIT piece, with law enforcement, we're a step ahead of you
3 on that, we actually worked with the International
4 Association of Police, their summit was focusing on crisis
5 intervention for people with mental illness and catching
6 them in crisis, and so we moved that guide throughout, but
7 I think we can do a lot more around that. And we have
8 already partnered there, as well.

9 I think on that, the community trauma, I think
10 that's an area where we need to really kind of think, how
11 do we address that? We have more, sort of, clinical kinds
12 of interventions around trauma, but in terms of more
13 community-wide piece, that's an area where we need to
14 really kind of figure out what can we do there, and what
15 are the kind of appropriate community level interventions
16 and population level. So, that's great.

17 Chairperson Hyde: Okay, almost all of you want
18 to say something, here. So, Hortensia, Arturo, Stephanie,
19 Ed, Judy and Cynthia.

20 Dr. Amaro: Okay --

21 Chairperson Hyde: Okay, we'll put you on the
22 list too, Terry.

1 Dr. Amaro: So, thank you so much for this
2 presentation and this is such a critical issue, we spent a
3 lot of time dealing with issues of trauma, and a lot of my
4 work has been involved with that.

5 I wanted to suggest that you also look at the
6 SAMHSA programs on HIV prevention. We have recently -- the
7 Boston Consortium Model which came out of the SAMHSA-funded
8 women Co-occurring Disorders and Violence Study, was put on
9 the NRAP Web site as an evidence-based model, and one of
10 our findings was that among women in substance abuse
11 treatment, the intervention group that got integrated --
12 trauma, mental health and addiction treatment -- did better
13 in all of those outcomes compared to the comparison group,
14 but also they had better HIV-related outcomes in terms of
15 risk behaviors.

16 And clinically, you know, my experience with
17 women who come through our treatment programs is that the,
18 you know, basic AIDS education 101 does nothing. You
19 really need to embed the issue of risk reduction around HIV
20 and STIs in the context of their trauma and mental health
21 histories, because that's sort of the nature of where the
22 risk comes from.

1 So, I think the use of trauma, treatment
2 intervention, is really needed in the HIV portfolio,
3 because probably, you know, the majority of the individuals
4 served in that portfolio are people with some history of
5 trauma. Whether you're talking about MSMs or women and men
6 who are in addiction, have a history of addiction or mental
7 illness. So, I would -- that's a suggestion. Because I
8 saw that you -- I didn't see those listed in the ones that
9 you were thinking about.

10 So, the other thing I wanted to suggest is also
11 making sure that in consideration are historical trauma,
12 also trauma related to immigration and refugee status. And
13 I'm, you know, you're probably thinking of these that just
14 didn't come out, as well as institutional trauma. You
15 know, we find that women come out of the criminal justice
16 system with more severe trauma than when they first went
17 in, and I think there needs to be some training.

18 In terms of other people in the healthcare
19 delivery system that need to be trained, you know, EMS
20 workers, emergency medical service, EMTs, technicians, for
21 example, you know, who go and pick up people, have contact
22 with people in crisis situations, in ambulances, have very

1 little training on issues of, really, in my experience,
2 addiction, how to deal with people who are mentally ill.
3 And I think that that would be, you know, a good target.

4 And then the last comment, regarding, you know,
5 what to do with the level of community intervention. In
6 public health, people who are looking at community-level
7 factors that are predictive of violence would be a good
8 group to turn to. The Kerwin Institute is doing research
9 on what's called Communities of Opportunity. And I think
10 we need to look at those upstream factors in terms of
11 prevention.

12 So -- and there's some literature in public
13 health showing some of the factors related -- both social
14 and physical features of neighborhoods -- that are related
15 to violence and exposure to trauma. So, that might be a
16 body of work to turn to.

17 Chairperson Hyde: That's great.

18 Let me just remind folks, because I'm already
19 feeling the balloon expand, here. One of the things in
20 this -- in this particular one is particularly amenable to
21 that is the possibilities are sort of endless on what we
22 could or should be doing. One of our struggles is what to

1 focus on, what is the one, or two, or three things that
2 SAMHSA really can focus on. Because we simply can't do it
3 all.

4 So, as you make your comments, if you can help us
5 think about that, that would be helpful.

6 So, Arturo, you're next.

7 Mr. Gonzales: Well, let me see if I can help you
8 focus a little bit, here.

9 If I -- it's good to see you again, Larke. If I
10 were in your shoes, you know, I think the prevention, or
11 the early detection of trauma is really important. The
12 trauma that at least I picked up that you were talking
13 about are, you know, people who are, women or youth who are
14 already in the correctional system or have been in the
15 correctional system, or whatever. And I'm concerned about
16 the potential for trauma and that not being detected, and
17 how do you do that? I would suggest that, you know, Pam
18 made a comment the other day, I was, you know, I'm
19 obviously very high on SBIRT. Pam's comment, if I
20 understood it well, is that SBIRT isn't the do-all, end-all
21 of everything, but it is a model that can be adapted for
22 doing some things.

1 And it seems to me that people are going to go
2 for services where they feel comfortable and they're likely
3 to feel that they're not stigmatized. And, for youth, it
4 could be their school -- high school health center -- for
5 the community it could be the community health center,
6 primary care physician. It would seem to me that if we
7 could develop -- as we did for substance abuse and
8 depression -- some evidence-based questions to determine
9 trauma wherein a person -- and make that part of the screen
10 when individuals go to see their primary care physician, or
11 they go the school-based health center or whatever, and
12 from that have a brief intervention with the individual to
13 determine the extent of that potential trauma. And, you
14 know, it could be child abuse, it could be rape, it could
15 be pedophile or whatever the thing is -- but to get a
16 handle on it, and then start referring internally for
17 either where that needs to be -- I think that would be a
18 real important piece of trying to work with trauma, not
19 just on the final end, but on the beginning end. I think
20 we ought to consider the SBIRT model for maybe doing that,
21 because we're already there.

22 The other thing --

1 Dr. Huang: Can I respond to that, before you --

2 Mr. Gonzales: Yes, yes.

3 Dr. Huang: We've actually --

4 Mr. Gonzales: No, no you can't, I'm not
5 finished, yet.

6 [Laughter.]

7 Dr. Huang: What a tough group you have, here,
8 Pam.

9 [Laughter.]

10 Dr. Huang: Just real quick -- we played with the
11 idea of the SBIRT in trauma, and don't quite know what the
12 brief intervention is for trauma, but it's a very good
13 point. And we're not just doing trauma at the back end, we
14 are trying to do the prevention of the screening early
15 intervention piece.

16 Mr. Gonzales: Okay. And I think the schools,
17 particularly, you have young people going through enough
18 pressure and tension in high school, the adjustments, and
19 they're getting temptations for drugs, they're getting
20 temptations for gangs, bullying for example, and I'm not
21 talking about my past history, here, you know, bullying, et
22 cetera, they don't quite fit into the norm. There's a

1 potential for trauma, there.

2 The other thing, following on Hortensia -- good
3 morning, Hortensia, I'm Arturo, I didn't get a chance to
4 meet you -- following Hortensia's comments, one of the
5 things that I think is happening in some of the southern
6 part of New Mexico is the trauma that's taking place from
7 people moving across the border because of the violence.
8 You know, you have people that are in the behavioral health
9 area, in El Paso, in New Mexico, and probably in Arizona,
10 in Nogales, et cetera, they're moving -- they're getting
11 their families to come to the United States and, you know,
12 not dealing with the immigration issue -- probably not
13 going to Arizona now, but --

14 [Laughter.]

15 Mr. Gonzales: -- not dealing with that, not
16 dealing with that -- there's trauma, there. You know,
17 there's trauma. They need healthcare. It's in -- they're
18 going to community health centers, and yet there's no way
19 to deal with that trauma.

20 And then, lastly, the Native American community -
21 - that's a tough one. You know, I guess I'm wondering --
22 I've seen the RFAs that come out to the Native American

1 communities, and you either have to be a Pueblo -- self-
2 determined Pueblo entity, or -- how do you get those funds
3 to the Native American community? Because, many of the
4 Pueblos may not be geared to apply for those funds, and
5 they need those dollars, but it has to be a Native American
6 entity that applies for that. And IHS, I don't know, is
7 not applying for some of that. But, I guess, Pam, I'm
8 wondering how do we improve the dialogue between IHS and
9 SAMHSA and maybe the policy piece of that, so that not just
10 the tribes can apply, but outside entities that work with
11 the tribes could be eligible for those funds, and go to the
12 tribes and try to work with them.

13 Chairperson Hyde: Quick response to that, and we
14 do want to move on to other comments. We're doing a lot of
15 work with IHS, Evette Rubineau and her leadership team have
16 come over and met with us and we're talking with them about
17 how we can do better. I think I mentioned Sheila Cooper
18 whose -- is Sheila here today? She wasn't here yesterday,
19 but she's back in town today, we might get her down just
20 to, so you can see her and introduce you to her -- I talked
21 about her yesterday. She's doing work with me and with all
22 of the folks in SAMHSA who are doing tribal issues to try

1 to look at how we can be better and expand on work that's
2 already been done about helping tribal communities get
3 access to dollars and get capacity developed to do grants,
4 et cetera. We're doing a lot of work in this area -- I'm
5 not saying, by any means, it's enough. But I think it's on
6 our radar, so good comments.

7 Obviously, the tribes feel very strongly about
8 who gets that money and who doesn't, so -- Stephanie,
9 you're next.

10 Dr. LeMelle: Hortensia commented on several
11 things that I was going to say, but I think -- I can't
12 emphasize enough, though, the impact on immigration, or
13 immigrants, into the United States. For two reasons: one
14 is that the rates of substance abuse and mental illness are
15 higher amongst recent immigrants into the United States,
16 and in terms of the overlap, as we talked about before,
17 with military families, a large number of recent immigrants
18 join the military with the promise of becoming citizens.
19 And in the military setting are discriminated against and
20 are exposed to trauma and other events. So, I think, as a
21 subpopulation, I think that's a really important group.

22 Chairperson Hyde: Ed?

1 Dr. Wang: God, I feel like I'm being a
2 cheerleader today because I said that, first of all, the
3 four messages, they were excellent, and I tied that to,
4 Kathryn, you talk about homeless permanent supportive
5 housing. I think this is another one area that I think
6 that we really, again, hit the marks in terms of SAMHSA.

7 Let me, actually, just go to Larke's last slide,
8 and just respond to that. I think part of it, because I'm
9 cheering, is that it is really the true focus in terms of
10 what's a, you know, a healthy community is about, you know,
11 in our country.

12 Place-based traumatic initiative, I think that's
13 an excellent idea, if I understood it correctly, is to look
14 at communities that are, you know, has the highest rates of
15 trauma. And we often identified what those communities are
16 at the local level, you know, in terms of certain parts of,
17 you know, inner-city rural areas, as well, that are really
18 highly traumatized through many, many factors, whether it's
19 refugees, immigrants, as well as other issues.

20 So, I think that if there's a way to look at
21 communities first and saying, "What can we do in regard to
22 education, awareness, services, intervention, preventions?"

1 I think that's great.

2 Bullet number two, you're seeing the public
3 health perspective, I think that -- I'm actually very
4 impressed by the slides of the ACES, you know, because, I
5 am going to use that, actually, as a way to talk to the
6 public health folks, as well as politicians -- I think it's
7 very clear, it's defined in terms of what the impacts are,
8 because of trauma, specifically on -- not only in terms
9 of mental health, mental illness, substance abuse, but
10 is also talking about, you know, the area of smoking
11 cessations, I am assuming they might even can look at
12 obesity and so forth --

13 Dr. Huang: Well, they tie it to cardiovascular
14 disease and diabetes, to other chronic health conditions.

15 Dr. Wang: So, it's, again, it's right on target,
16 it's very much, in terms of community base, from a public
17 health model.

18 The third bullet, as I said, you know, they are
19 traumatized as both historical and I think, more into acute
20 trauma, you know, kids that are, you know, talk about kids
21 walking to school. Recently I just came across a situation
22 where there was a shooting in the neighborhood, how the

1 principal immediately have to, you know, lock all of the
2 doors and so forth, and I say, "Geez, you know, we have
3 kids growing up in that environment that has, you know,
4 suffered from what's happening in terms of crimes, and
5 violence, and so forth." So, I think it's, again, it's
6 really right on target.

7 I think one of the challenges, though, is that I
8 was looking at all of the multiple efforts of, you know,
9 all of the slides of the SAMHSA initiative. Community, I
10 think, is harder to respond in terms of multiple
11 initiatives, in a sense, but it actually is better if the
12 committee as a whole, looking at how these initiatives can
13 fit into that community. So, I think the challenge for
14 SAMHSA is probably to say, how do we do that? How do we
15 support, you know, the place-based initiative? It's not
16 just drug court, it is not just safe school, how do you
17 work as a whole for those community at high risk?

18 The other aspect is I just want to emphasize, in
19 terms of partnership, is that the NIH Directors, the
20 opportunity for research in the five thematic areas, I
21 think that we can actually put science into what we do in
22 terms of trauma. And I think, specifically it's in the

1 area of informatics, and human informatics and network
2 science, that you can actually apply towards one of the
3 thematic areas is called information of human adaptation.
4 And I think, in many ways, this is what we're talking about
5 -- how humans can adapt in some very violent situation and
6 how we can prevent that, and how, would you talk about, and
7 then, you also talk about treatment, as well.

8 Chairperson Hyde: That's great. We actually did
9 have one meeting of NIH, NIDA and NIAAA and just to say
10 hello, together I think there's a lot of efforts the four
11 of us could do together, so this is a great idea.

12 Judy, you're next.

13 Ms. Cushing: Larke, this is really great work,
14 and I concur with Ed on the place-based initiatives on
15 trauma, I think it's a brilliant concept, and I'd be
16 interested in learning more about that.

17 I wanted to comment on target number four in your
18 crisis first responders. Great that you've reached out to
19 IACP, but as you're thinking about community, we had an
20 interesting thing happen. We had a very tragic death of a
21 severely mentally ill individual in Portland, the downtown
22 streets of Portland that became front-page headlines and

1 remained there. The individual was killed in the process
2 of his trying to be arrested by a police officer. That
3 resulted in some really robust discussions about how much
4 law enforcement agencies understand about mental health
5 issues and addiction issues, et cetera.

6 As a result, the Police Bureau, the Portland
7 Police Bureau reached out to us and asked us to train their
8 hostage negotiation teams, which we've now done two of --
9 the State Police have now contacted us, I'm thinking of all
10 of the SAMHSA partners and grantees who you might reach out
11 to who are local level mental health providers or crisis
12 response agencies who could help train law enforcement
13 entities in understanding mental health issues.

14 The win for us was the police wanted to actually
15 implement after the training, and they also went through
16 the ASSIST training, Kathryn, which was very interesting.
17 They wanted to volunteer on the lines, and they have. And
18 they've taught us so much, and they said they've learned a
19 lot themselves, it's been a tremendous partnership. Just a
20 suggestion.

21 Chairperson Hyde: Okay, I've got three more
22 comments, and then we'll let Larke do a final comment, and

1 then we'll move into the next one, because it's time for
2 that.

3 So, Cynthia, Terry, and then Don.

4 Ms. Wainscott: I'll be quick, I also love the
5 energy and focus that this process is bringing.

6 Under target five, Larke, ensuring that service
7 sectors are not re-traumatized, the goal of preventing and
8 reducing seclusion and restraint feels like a bit of a
9 retreat, to me, from the good work that's been done in
10 recent years, and I would propose that we think about
11 saying "eliminating seclusion and restraint in treatment
12 settings," perhaps add schools? Kathryn, that would be a
13 job for you.

14 In Georgia, we've just had a big headline with a
15 child who was sent to a "feel better" room, and died. What
16 I suggest is eliminating seclusion and restraint in
17 treatment settings and possibly adding schools, and
18 reducing it in other settings. We're not going to
19 eliminate it in jails and prisons, you know, but I don't
20 want to let go of eliminating it in treatment settings, if
21 we can.

22 Chairperson Hyde: Okay, thanks.

1 Terry? Terry, you're on.

2 Mr. Cross: Yeah, thank you very much.

3 I just wanted to bring to your attention, the
4 institutional trauma for Native youth in juvenile justice
5 settings, we have some data that shows that Native American
6 youth are the most likely to be held in four-point
7 restraint, mostly likely to be held in seclusion, most
8 likely to be pepper sprayed, and most likely to die in care
9 in juvenile justice facilities, and it's really gotten no
10 attention because there's no -- the issues with regard to
11 how juveniles are handled in the justice system is really
12 an untold story, and most of them are in Federal
13 facilities. And the rules that apply to States under the
14 juvenile delinquency prevention statute are not applicable
15 to Federal facilities. So, there needs to be some change
16 at the Federal level to reduce the amount of trauma that
17 users are facing in those settings.

18 Chairperson Hyde: Great, Terry.

19 We're -- Larke and I are actually working with
20 some other staff on the Juvenile Justice Council that the
21 Attorney General runs, so we'll make sure that Larke gets
22 with you and gets the data and the other information you

1 have about that.

2 Do you have anything else about that right now,
3 Larke?

4 Dr. Huang: Not particularly on that, but we'll
5 take that into the Coordinating Council discussions.

6 Chairperson Hyde: Okay, Don, you have the last
7 comment on this one, and then we'll go back to Larke.

8 Dr. Rosen: Again, I'd like to echo the comments
9 of a lot of other people about the quality of the work that
10 you're doing and the presentation that you made and only
11 briefly to echo some of the comments that have been put
12 forth here about the importance of addressing immigration
13 and refugees.

14 I've actually given a fair number of talks in
15 schools around helping identify trauma, and your slides, in
16 particular, about how practice doesn't make perfect,
17 practice makes it worse -- the more trauma you have the
18 worse off the prognosis is. And one of the drive-home
19 points we try to make is, just because you don't want to
20 talk about it, doesn't mean we can't help. And similarly,
21 the comments that were made about corrections -- and it's
22 true, there's awful trauma that occurs in corrections, but

1 there's trauma that occurs in transitions out of
2 corrections. One of the things that we've tried to address
3 is the trauma of leaving prison after 8, 10, 12 years and
4 that's it, thanks.

5 Chairperson Hyde: Okay, Larke, you want to wrap
6 this one up and then go ahead and move into the next one?
7 This is a very rich discussion, as they've all been, but
8 this is great, thank you.

9 Dr. Huang: First of all, I'm really pleased that
10 people think that this is an important initiative and your
11 recommendations are really right on target. I'm actually
12 pleasantly surprised with the focus on immigrant and
13 refugees. I had done a lot of work in that when I was in
14 California, so I'm glad to hear that and glad to see how we
15 can incorporate that here, as well.

16 I guess I want to just say that, you know, I'm
17 open, we're open to, as you think further on this, to
18 sending in comments, we're trying to really figure out
19 exactly, as Pam said, what can we do in this first year
20 around it, it's obviously a multi-year, multi-sectoral
21 strategy that we're going to go forward with, so I
22 appreciate, you know, your input very much.

1 Chairperson Hyde: Okay, Jobs and the Economy,
2 another just little small initiative, here.

3 [Laughter.]

4 Chairperson Hyde: And it is, let's make sure you
5 know where it's at, it's page -- you may find this faster
6 than we do at this point. Jobs and the Economy is on slide
7 19, and it's on page 9 of your Fast Facts.

8 As you can see, these facts actually evolve. So,
9 this is -- we've probably had 10 versions of this, and even
10 I'm seeing more facts that the presenters have, here, so we
11 are continuing to try to evolve these into pithy ways of
12 saying why these are important, so --

13 Dr. Huang: Yeah. And we're always getting new
14 data on these things and we try to keep these really
15 updated and timely.

16 So, I have another small initiative, here, Jobs
17 and the Economy. Again, there are some Fast Facts, there,
18 I'm not going to read through those, you can see them, but
19 I'm -- it's interesting, because as you start working on
20 these initiatives, and as we talk with the other initiative
21 leads, we really see how they're very tied together. So,
22 if you pull out, you know, the fourth bullet, we know that

1 there's a 1 percent increase in employment is associated
2 with a commensurate increase in child maltreatment. So,
3 that gets us right back into the Trauma and Justice, you
4 know, initiative, as well. So, these things are very
5 intimately linked, in ways.

6 So, we're really looking at trauma and -- well,
7 here is actually some more data, I think you have this
8 data, also. We wanted to also just give you some updated,
9 just kind of what the current Bureau of Labor statistics
10 data is, in terms of unemployment, and unemployment as it
11 affects different populations, and particularly populations
12 of color, particularly populations who are already on the
13 poverty end of the spectrum. They are at increased --
14 there's like a 30 percent rate of unemployment on that end
15 of the spectrum, as opposed to the more affluent end, where
16 we see maybe 1 to 3 percent. So, we're also seeing
17 multiple risk factors for certain populations and
18 communities.

19 This is from our NSDUH data, in terms of looking
20 at employment -- full-time, part-time, unemployed, and how
21 that is associated with past year's substance use, past
22 year's serious psychological stress, and past year co-

1 occurrence. And so that, you can see that those kinds of
2 conditions are associated with increasing levels of
3 unemployment from full-time to part-time unemployment.

4 Okay, so again, we started here in our work with
5 kind of three framing questions, and unlike the Trauma and
6 Justice initiative, this initiative does not have a
7 particular initiatives or programs, grants or contracts
8 focused on jobs and the economy.

9 So, we were sort of starting from a little bit of
10 scratch, although as we dug deeper we found we have
11 different pockets of activity going on, and how can we best
12 organize them, what would be a good organizing framework
13 for ourselves at SAMHSA, and then also, if we can get that
14 framework clear to us, it's easier for us to, then, work
15 with our partners in terms of how they enter in, in certain
16 activities within this framework.

17 So, we asked, you know, what can SAMHSA do to,
18 one, reduce the negative behavioral effects of the economic
19 downturn, of recession times? Secondly, how can we improve
20 employment outcomes for people with mental and addiction
21 disorders, and three, how can we improve behavioral health,
22 and support recovery, in the workplace?

1 Those became what we called, sort of, our three
2 buckets in this initiative, and we were going to try to
3 organize our thinking, our work, our resources, our
4 outreach around these particular buckets.

5 So, if you look at target one, reducing the
6 impact of the recession, our target one was really looking
7 at individuals and families in economically distressed
8 communities. A goal to reduce the impact of the recession
9 on behavioral health well-being of individuals and families
10 in economically -- I'm sorry, that should say "economically
11 distressed communities." And we looked at what happens in
12 economic downturns in terms of behavioral health. And some
13 people say, "Well, substance abuse goes up." Well,
14 substance abuse doesn't go up just across the board. In
15 terms of illicit drug use, in terms of having the resources
16 to buy or access those, those don't necessarily go up. But
17 we know that alcohol goes up and binge alcohol drinking
18 goes up, and therefore alcohol-related hospitalizations go
19 up.

20 We know that, actually, teen violence goes up, we
21 know depression and anxiety and family -- domestic violence
22 and disillusion goes up. So, we're really trying to not

1 just say all these bad things happen, we really wanted to
2 be a little targeted in our thinking around it. Because we
3 wanted to really think about, how do you redesign care
4 pathways and -- in these communities as they face these
5 stresses, but also as families and individuals are facing
6 those, the behavioral health system of supports is
7 simultaneously facing cuts in their capacity to serve
8 people. Okay, so we have two simultaneous things --
9 drastic things, actually, going on at the same time.

10 So, we wanted to look at our objectives -- how
11 can we redesign some of these care pathways, how can we
12 increase the number of readily accessible places to provide
13 early identification, brief interventions, prevent the need
14 for more intensive services. Kind of what you were saying,
15 Arturo, get at the front end of things so we're not just
16 moving and referring people to services that have
17 diminished capacity in harder economic times with State
18 budgets and local budget cuts.

19 How do we increase psychosocial motivational
20 support for residents to reenter the job market? So, we
21 wanted to not move people into sort of chronic sense of
22 joblessness, but kind of prevent that chronicity, and

1 decrease behaviors that historically associated with
2 economic crises, which I just ran through.

3 Okay, so our approach on this -- we have
4 developed a new grant program which just hit the streets
5 earlier this month, and is -- applications are due in at
6 the end of this month -- in what we're calling the
7 Community Recovery and Resilience Initiative. And this is
8 our, sort of, first attempt at doing a place-based
9 initiative within SAMHSA and blending some of our
10 resources. And this is a tiered approach, so tiered public
11 health approach, looking at, first, universally in a given
12 community, how can we infuse informational materials around
13 the behavioral health impact of economic distress, and
14 promote that self-help support or the neighbor-to-neighbor
15 kind of support, or building on internal resiliency in the
16 population.

17 The second level is, really, looking at more of a
18 menu of evidence-based prevention practice that target
19 risks, such as alcohol misuse, depression, anxiety, family
20 violence, other job-related behavioral health problems, and
21 do those, not necessarily in behavioral health venues, but
22 in churches -- we have great faith-based partners, or in

1 primary care, or in job centers, or in one-stop employment
2 centers.

3 And then looking at, again, increasing level of
4 risk, looking at an SBIRT, an SBIRT for alcohol,
5 depression, and anxiety, given we know those are the issues
6 that come up in these -- in the face of job loss, and how
7 can we put those in multiple community settings in a
8 community.

9 And then the fourth level, more intensive, crisis
10 intervention, and more intensive behavioral health
11 treatment for people who are really in a behavioral health
12 crisis related to the economy or to job loss. Also, at
13 level one, we would also involve information -- include
14 information about suicide hotlines, and you may have heard,
15 I guess, in prevention earlier that we've had increased
16 number of calls to hotlines -- about 50 percent of them to
17 our suicide hotline, now, related to job loss and the
18 economy.

19 So, we have a -- we have -- and then we also --
20 and I should say, this was a cross-center effort, so that
21 each of the centers is involved in terms of either funding
22 a piece of it, or providing technical assistance, or using

1 their evidence-based interventions. We went to Fran to get
2 Fran's six key evidence-based interventions for promotion,
3 I mean, for prevention of these disorders. We went to
4 Kathryn for a lot of the community resiliency work, we went
5 to Wes for the, you know, implementing SBIRT in this. We
6 went back to Wes for involving drug courts in this, as
7 well. We think about drug courts as an important community
8 intervention to keep people out of incarceration, we know
9 that we blended those funds as a supplemental option in
10 this -- in this grant.

11 It also, very much, related to jobs. If we can
12 keep people with substance use issues out of incarceration,
13 it reduces a barrier that they often have to get
14 employment, if they've been incarcerated with a substance
15 abuse history.

16 So, that's our approach in this first CRR I, we
17 call it, CRR I, and we did a lot of that as we were trying
18 to get it together --

19 [Laughter.]

20 Dr. Huang: And Dara was great in terms of making
21 it work in terms of the funding pieces, and we've had --
22 we've had probably up about 40 inquiries about this

1 project, and we hope to have applications in at the end of
2 this month.

3 Our second target was really looking at
4 individuals with mental health and substance use disorders
5 that are unemployed and seeking employment, or employed and
6 at-risk of losing their jobs. And if you think about our
7 recovery framed -- you know, housing, jobs are critical
8 pieces of that. You know, not to diminish the value of our
9 treatment interventions, but sometimes getting somebody a
10 job is equally as effective in their recovery as some of
11 the other clinical interventions that we do.

12 So, we want to increase the percent of
13 individuals with mental and substance use disorders who are
14 meaningfully employed. These are some of our objectives,
15 here, and we are actually involved in carrying out some of
16 these right now.

17 Okay, so we have done -- we have an evidence-
18 based intervention, a toolkit which is going to be re-
19 released, in a new format, which focuses on supported
20 employment. So, we look at how can we get this
21 intervention, okay, into our various grant programs, or
22 into communities and to -- and also include a priority

1 focus on this, on youth and transition.

2 We also are looking at how can we promote
3 recovery, independence and employment through
4 entrepreneurship, through self-employment, and self-
5 entrepreneurship for people in recovery, and we look at
6 some of that happening, now, with some of our peer-operated
7 services, our consumer self-employment and recovery-
8 operated service, as we look at increasing numbers, and
9 Cynthia knows, and has spoken about this, about consumer-
10 operated respite and crisis intervention services now, that
11 are not only having good uptake among consumer and consumer
12 use, but they are also utilizing employment opportunities
13 for consumers to, in fact, operate those crisis recovery
14 centers.

15 We have a number of different kinds of hiring
16 policies, we have a 2 percent initiative, here, in our
17 Department, our Secretary's 2 percent initiative to hire 2
18 percent of each Agency should be people with various kinds
19 of disabilities. We thought -- and we have a Schedule A
20 already in practice, hiring policy around that. We
21 thought, "Well, maybe this is something we can do in our
22 grants and contracts," if we're going to sort of practice

1 what we're preaching that we can -- and we actually ran it
2 by our Contracts Office, we can do that -- we don't know
3 about our grants, yet, in terms of having an expectation
4 that they are hiring people in substance use or mental
5 health recovery, you know, as they're hiring up to
6 implement their grants or their contracts.

7 We're trying to also look more at the barrier of
8 crimes issues that are related to substance use and that
9 are impediments to people who have substance use histories
10 and have incarceration histories as impediments to
11 employment. We are also having an employment summit in the
12 fall to really look at some of these policies -- cross-
13 agency policies -- and that get in the way of employment
14 for our population.

15 We actually are building partnerships with some
16 of our Federal agencies, we are working with a new partner,
17 the Internal Revenue Service, which is -- we haven't really
18 done a lot of work with them and we really haven't had them
19 on our radar screen. But, really looking at, can there be
20 tax incentives for hiring people with disabilities in
21 recovery from addictions?

22 We are working with the Department of Labor, they

1 realize that many of their programs, which are employment-
2 related programs, their job corps, their Youth Build
3 programs their reentry programs, and now they just let us
4 know about a transitional jobs program, where substance use
5 issues are a problem. And where, for example, in their
6 Youth Build program, which is getting youth into
7 construction industry, and getting their GED, that they may
8 invest in the GED and the training, and then when they do
9 their drug testing, they've got substance use issues. So,
10 their investment in them falls out. And various grantees
11 have different policies around -- ranging from zero-
12 tolerance to support services for youth with substance
13 abuse.

14 So, they are very interested in our SBIRT
15 program, and our effective adolescent treatment programs.
16 So, we are working with them to see how we can build up
17 that capacity within their Youth Build Programs.

18 Okay, I'm talking too much.

19 Employers and the Workplace. We also want to
20 look at how we can provide workplace environments, in terms
21 of their benefits and policies, that support the behavioral
22 health of their employees and reduce such things as

1 absenteeism, presenteeism related to behavioral health
2 issues and increased work productivity. A lot of our work,
3 here, is focusing on working with employee-assistance
4 programs and the Association of Employee Assistance
5 Programs and we have a number of efforts already going on,
6 here. We have a connection in several -- and actually all
7 three of our centers -- doing work with the National
8 Business Group on Health, in terms of looking at employers'
9 guides to behavioral health in the workplace. We have a
10 major initiative around looking at SBIRT and training EAPs
11 in the SBIRT model and clinicians that they contract with
12 through EAPs, and working with Department of Labor on an
13 informational Web site that they have closed down on
14 looking at drug-free workplaces.

15 And then, since Pete's here, I have to state
16 target four is our data strategy and that is really looking
17 at analysis of employment issues in mental health and
18 substance abuse, and we have a small study with NIMH that,
19 in our meeting with them, they remind us about and we're
20 very excited about, looking at the impact of the economy on
21 mental health and looking at them through a data points in
22 NSDUH. And we've actually just started talking about, with

1 our block grant folks, about how they're tracking supported
2 employment, and what measures we can get out of that.

3 Okay, that's it.

4 Chairperson Hyde: Thanks, Larke.

5 Obviously lots going on, here. Who wants to
6 start on this one?

7 [No response.]

8 Chairperson Hyde: Have we worn you down?

9 [Laughter.]

10 Chairperson Hyde: Hortensia?

11 Dr. Amaro: So, I was really happy to see, Larke,
12 the entrepreneurship piece. We have, in one of our SAMHSA
13 grants for women returning, reentering the community after
14 incarceration, in addition to sort of the mental health and
15 trauma and all of the other service we usually provide,
16 we're developing a model with the college of business at
17 our university on entrepreneurship training for women
18 returning to the community after incarceration, and they
19 did something similar with trafficked women a couple of
20 years ago and so we're just about to go into the piloting
21 of the intervention. But, I'd be very interested in just
22 knowing from you, more about what models you guys are

1 thinking of using, or if you need information would be
2 useful from us.

3 But, you know, the idea is that, actually, a lot
4 of people who have been involved, you know, who have a drug
5 addiction history have some good entrepreneurship skills,
6 just applied to the wrong set of activities.

7 And so, I'm really interested in this, I think
8 it's very innovative, and I'd love to hear more about it.

9 I did want to comment, sort of, separately on the
10 data strategies, and I'm not sure who this question would
11 be for, maybe Pete, or you, but my understanding is that
12 the national data set on treatment utilization, that is
13 under SAMHSA has stopped collecting some data on place of
14 birth and perhaps Hispanic-specific groups. I was about to
15 start doing some data analysis with that data set and I was
16 informed of that.

17 And so, if we're looking at data strategies,
18 anything -- I mean, this applies for the issue we're
19 talking about now, but for some of the other ones, I think
20 we need to take a look at whether that's true, and those
21 elements -- or any other elements -- that maybe we're not
22 collecting, to really help us answering some of the

1 questions related to treatment utilization that we've been
2 discussing throughout the day.

3 Chairperson Hyde: We did do a whole thing on
4 data and outcomes yesterday, so if there's specific things
5 you have, I would just ask you to talk offline with Pete --

6 Dr. Amaro: Okay, sure.

7 Chairperson Hyde: Because we -- and if it's
8 specific to jobs and the economy, go ahead and bring it up,
9 but if you have other things I'd just go ahead and talk to
10 Pete.

11 Dr. Amaro: No, I just want to make sure that
12 whatever the data sets that we're -- they're able to
13 address the various issues that we've brought up about
14 different demographic populations.

15 Chairperson Hyde: Stephanie?

16 Dr. LeMelle: Well, just in thinking about the
17 entrepreneurship -- and I'm not sure if this is okay to
18 talk about or not -- but, you know, the Van Jones
19 initiative, you know, of really working with folks who are
20 coming out of the criminal justice system and getting them
21 involved in green industries is still, I think, an area
22 that hasn't really been tapped as well as it could be,

1 particularly with the population that we're talking about.
2 So, if, you know, if there's a way to look at the green
3 industries and helping people to be skilled in those areas,
4 I think it's a job opportunity that's wide open.

5 Dr. Huang: Right, that's a good point. We have
6 a connection at Labor that's involved in the green
7 industries jobs, too.

8 Chairperson Hyde: I just was going to ask if you
9 wanted to say more about that for anybody who might not
10 know what that is.

11 Dr. LeMelle: Sure. Van Jones is -- I guess an
12 entrepreneur -- who started a project, I believe, in
13 California, initially, where he was working with people who
14 were primarily African-Americans and minorities who were in
15 prison, and training them to be technicians in green
16 industries, so teaching them how to do geothermal
17 installations, and photovoltaic cell installations,
18 windmill installations -- all of the green industries. And
19 he did a training program, in the prison system, so that
20 when people, then, were released from prison, they went
21 into the workforce in the green industries. And he had
22 connections with some companies -- private companies --

1 that were hiring folks as they were coming out.

2 Chairperson Hyde: Okay, great.

3 Anybody else have comments on this one?

4 Yes, Larry?

5 Dr. Lehmann: Was it really -- what really came
6 off of is a slide that talked about community recovery and
7 resilience. Because this is something that I was thinking
8 about in the previous presentation, about trauma. And,
9 really, it keys off of the work that we're doing with our
10 DoD colleagues to try to promote resilience to stress, in
11 DoD, it's combat stress. But the idea is if you train
12 people to be able to have coping mechanisms and problem-
13 solving skills, and those are really the two approach, the
14 cognitive behavioral coping approach, or problem-solving
15 skills approach that we're looking that, they'll be better
16 able to handle a stressful situation when it comes up.
17 This is very much a public health kind of issue, because it
18 isn't just in military, and it isn't just with regard to
19 community violence, and it isn't just with regard to the
20 economic downturn issues.

21 But, if you really can begin to find methods that
22 work, and teach and train people, literally from -- in the

1 schools -- how to deal with these kinds of problems, you'll
2 be doing a major thing for helping people have a skill set
3 and a tool set that they don't have, yet.

4 So, yes, we've got to get the research to prove
5 that these things work. But, it's very important to keep
6 our minds on that broader public health application for
7 these things that I think can be very, very helpful down
8 the line in the future for decreasing some of the emotional
9 and psychological consequence of a wide range of traumatic,
10 stressful situations.

11 Chairperson Hyde: Actually, I think you're
12 taking us in a very nice way all the way back to our
13 prevention initiative, because the IOM study is really
14 pretty clear, I think, or the book that has a lot of
15 studies, is about the -- a need to teach risk and
16 resiliency -- or resiliency skills to very young people,
17 very young kids. So, I think you're making a very good
18 point.

19 Anybody else?

20 [No response.]

21 Chairperson Hyde: I think we have worn you down.
22 This is the first time you've stopped before the time.

1 So, let me let Larke -- if everybody's done with
2 that -- let me let Larke wrap up, and then I will introduce
3 somebody else to you, and then we'll go to lunch.

4 Dr. Huang: Okay. Well, again, I just want to
5 thank you for your comments. I think you hit it on target
6 when we were trying to look at that public health risk and
7 resiliency, that we know that there are risk factors that
8 go for a number of different conditions, and protective
9 factors, so we're really trying to build that in to
10 individuals, families, and communities across different
11 conditions.

12 Any information, I'd be happy to share with you
13 later, or if you want to send me information, Hortensia, if
14 you want to send us about, you know, the Institute you were
15 talking to, we'd certainly be interested in that, and
16 again, open to your input on each of these initiatives.
17 Thanks very much.

18 Chairperson Hyde: I do want to make sure you
19 know on this one, the CRRI initiative that Larke talked
20 about was, not the first, but it certainly was something
21 that the staff really responded to quickly when we were
22 getting a request from the Secretary's Office, which

1 emanated from the White House, about a place-based
2 initiative where we were really trying to bring multiple
3 programs together to braid them, remember how we talked
4 about that yesterday? So, this was definitely a braided
5 funding kind of approach where a particular geographic area
6 can -- or community, however you want to think of it -- can
7 apply for multiple programs at once, and the White House is
8 very interested in expanding that construct. So, we've
9 talked about it, kind of off and on in a couple of
10 different places. But, I think you will see additional
11 efforts on our part to put multiple programs together so
12 that one applicant, for one geographic area, can ask for
13 several different of our programs.

14 Frankly, the tribes have talked about that, too.
15 In a different way, and for a different reason, but it's
16 the same principle, which is, you know, we -- make us jump
17 through all of these hoops to get a variety of different
18 programs, and it would really help if we could just say
19 what our community needs and put that together.

20 That bumps up against, a little bit, some of
21 Congress' need to give us specific appropriations for
22 specific things, but we are trying to push the edges and

1 boundaries of that a little bit. So, that's partly this
2 initiative, and again, I don't know if you paid attention,
3 this was quite a bit of money for the small number of
4 grants. We actually want to probably only give two or
5 three grants, if we can, because the idea is to really also
6 see if we can put enough resources into one place that it
7 really makes an impact on that place -- that city, that
8 community, that whatever. And that could, ultimately, have
9 impacts on a lot of things -- from our prevention
10 initiatives to other things.

11 Because, again, since I have the time, I'll
12 ruminate here for a second, I do worry sometimes that our
13 grants are, relatively speaking, small for the problem
14 we're trying to fix -- it's not necessarily small in terms
15 of the grantee trying to manage it, but small in terms of
16 the problem we're trying to deal with, and then we -- the
17 grants, unfortunately, go away in three to four to five
18 years.

19 So, just thinking how to have a real impact in a
20 particular area or show that this is one of those ones we
21 call "proof of concept," trying to prove the concept of
22 putting multiple programs, more resources into one area can

1 really, actually, have an impact. It's sort of like the
2 housing one where we're trying to really prove and show
3 that if you put the services together in the right way,
4 across multiple Departments, you really can affect the
5 permanent homeless -- permanent housing for people.

6 So, that kind of concept, I think, you'll see
7 come alone in more places.

8 So, I wanted to just have you see a face to
9 Sheila Cooper, who is our Native American Special Advisor,
10 or Assistant. Again, I always get these names wrong. But
11 nevertheless, I mentioned her yesterday, and tribal issues
12 have come up several times, Sheila, so I just wanted them
13 to have a face with the name. And she's going to be
14 working on all of our tribal issues, but with, also, our
15 National Advisory Committee, Tribal Advisory Committee,
16 which we have a specific group that works on those issues.
17 So, I don't know if you want to say a word or two, Sheila,
18 just to say hi?

19 Ms. Cooper: Hello, greetings. Hi, I'm Sheila
20 Cooper, I'm an enrolled member of the Seneca Nation from
21 the Cattaraugus Territory. I believe one of your esteemed
22 committee members, Terry, is from the other reservation,

1 but we overlook that back home.

2 [Laughter.]

3 Ms. Cooper: A little bit about my background, I
4 was the Program Operations Director at the Administration
5 for Native Americans for 10 years at the Administration for
6 Children and Family. So, I apologize for not joining the
7 group earlier, but I have been listening to the
8 conversations this morning. Note to self -- close your
9 door and run away so no one comes in so you can go and meet
10 interesting people.

11 And in that capacity, I worked not only with
12 American Indians and Alaskan Natives on social and economic
13 development in creating healthy communities -- Native
14 communities, wherever they are, whether they're
15 reservation-based or in urban settings, but I also am
16 familiar with working with Native Hawaiians and Native
17 populations in the three territories.

18 So, I have been listening to the conversation,
19 and also I'm very well-versed in discretionary grant
20 programs within ACF. So, I'm bringing that experience
21 here. I hope to contribute as much as I can to these ten
22 initiatives, I know that every one of these embedded in

1 Indian Country, and thank you for allowing me to speak this
2 morning.

3 Chairperson Hyde: Great.

4 Does any -- since we have a minute or two, does
5 anybody have any questions of Sheila? Because different
6 tribal things came up, as you can see, it's across all of
7 these initiatives. Any questions for her, right now?

8 Ms. Cooper: I just concluded a tour of the HHS
9 Regional Consultations, which started in Seattle and went
10 on to Anchorage and then ended up with Denver last week, so
11 I was able to meet and greet and also listen to the tribes,
12 from their perspective, on issues that they've raised for
13 many years, and hopefully will be able to provide with some
14 resources and some answers over the next coming year.

15 Chairperson Hyde: I think the -- I have
16 participated in a couple of these, and I think that the
17 themes are pretty clear. One is the frustration about
18 getting access to dollars, and they are always very
19 complimentary of what SAMHSA has done under Dr. Broderick
20 and the rest of the folks in trying to make it easier, and
21 trying to build capacity and trying to help tribes get
22 access to dollars. But, they need more. They want more,

1 and need more help about that, and have feelings about how
2 that money should flow, et cetera.

3 The other two big issues is just help with
4 substance abuse, and help with suicide. Those are the
5 three main themes that just keep coming up over and over
6 again and a variety of variations. So, we're taking that
7 under advisement and trying to respond for -- as HHS is
8 asking us to, the Department is asking us to respond
9 because they're also really trying to get feedback to the
10 tribes about what we're doing about what they give us, the
11 input they give us.

12 So, when we break, here, if you want to say hello
13 to Sheila, you're welcome to do that. We've got a couple
14 of other things before we break. This is something I
15 referenced yesterday that this was about to come out, and
16 so it's out, and so you get it, hot off the presses. This
17 is SAMHSA News, which I'm sure you've gotten before, but
18 right inside is the issue we talked about, about what's in
19 a term. So, you can take a look at that, and that whole
20 discussion about use of the terms "behavioral health" and
21 "mental health" and "substance abuse" and "substance use
22 disorders" and all of that good stuff, you can take a look

1 at as well as the other good stuff that's in there.

2 I think Toian has a logistical issue or two
3 before we talk about the afternoon?

4 Ms. Vaughn: It's just some administrative
5 responsibilities, here. With regard to the lunch, the
6 lunch has arrived, and you'll dine over in the room where
7 you were yesterday. For those individuals who have not
8 paid for your lunch, it is ten dollars, and I ask that you
9 give the money to me.

10 The other thing is that, before you leave today,
11 I ask that you complete the certification form so that you
12 can get paid. That's the -- we want this -- I would like
13 to have it before you leave.

14 In addition, I think that only one of you will be
15 completing the waiver of compensation form, in which you
16 can waive receipt of monies for the honorarium and/or the
17 travel and per diem. If anyone else -- we have one copy,
18 but if there are any others that we need to receive, I'd
19 like to receive that before you leave.

20 Now, you do have the expense form. This one you
21 will take with you, and then you will return it with your
22 receipts within 5 days after you get back, so that we can

1 reimburse you for your expenses.

2 One other thing is that, if there's anyone here
3 who would like to make a public comment, I would ask that
4 you see Nevine. Public comment is set -- the time is set
5 for 2:15, so we'd like for you to register so that we can
6 know, be aware that you're making a public comment. And if
7 you are on the -- for those individuals that are online, we
8 would like for you to call into the following number, 1-
9 800-857-9877, the password is SAMHSA. Again, it's 1-800-
10 857-9877, and the password is SAMHSA.

11 Thank you.

12 Chairperson Hyde: And that call-in is at 2:30
13 when we do the --

14 Ms. Vaughn: 2:15, yes.

15 Chairperson Hyde: When we do the public input
16 process.

17 Ms. Vaughn: Yes.

18 Chairperson Hyde: And for people on the --
19 listening by Web, or participating that way, please stay
20 with us a little bit, because we're trying to stay, very
21 much, on time. But should we, by some chance, end the
22 conversation early, we'll go right into public comments.

1 So, please stay with us, it could be 2:15 -- it will be no
2 later than 2:15, but it could be a few minutes earlier than
3 that. So, stay with us.

4 All right, so let me just say one or two other
5 things so we'll be all ready for the discussion this
6 afternoon. We did talk yesterday, and since there's one or
7 two other members that joined us today, I want to remind
8 you that if you have anything else to tell us, especially
9 around the 10 initiatives, please go to the lead of the ten
10 initiatives -- go to the lead of that initiative -- and
11 also please copy, or let Toian know, as well, so she can
12 just kind of keep track of what our Advisory Committee
13 interactions are.

14 So, if you're emailing, or sending materials, or
15 whatever, if you'll just cc: Toian, that would be really
16 helpful.

17 If there's something you want to say that you
18 haven't had a chance to do, or you don't have a chance to
19 do with the leads, or you don't know where it fits, which
20 initiative it fits with, then you can also do that through
21 Toian, and will make sure it gets to me, or Ben, or whoever
22 else needs to get it. And I say that, in part, not because

1 I'm not personally willing to chat with you -- I am. I
2 just can tell you that my calendar is such that you will be
3 frustrated at trying to get a hold of me sometimes. So, if
4 you can do that with Toian, we can manage getting feedback
5 to you, or getting the interaction with you in the best
6 way.

7 All right, so this has been a hugely, hugely
8 wonderful day and a half, we have a partial -- part of a
9 half a day to go -- and this is the time where you get to
10 be a little less controlled in your responses, because
11 we're going to have a presentation this afternoon -- just a
12 few minutes -- from Faye and Tom -- about the work they did
13 on the paper that you've had. We are assuming you've read
14 the paper, so they're not going to present the paper.
15 They're going to present a few highlights, then we're going
16 to talk about that.

17 We'll have some open discussion, then, not just
18 on the paper, but on all you've heard, how you feel like
19 that's fitting together, and next steps, et cetera. We --
20 anything else, then, that we haven't talked about, that
21 you'd like to put on the table, and we'll do those, sort
22 of, in sequence.

1 And then, we do need to talk just a little bit
2 about next step and next meetings. We, obviously, are
3 going to be focuses on these ten initiatives a whole lot.
4 And so questions you may want to think about over lunch is,
5 what can we do at the next meeting that would be most
6 meaningful to you? Updates, where should we meet, because
7 those are issues, and are there places to meet that would
8 highlight one of these initiatives, or is there something
9 else about that we should think about? So, think about
10 those things, as well.

11 And then we'll go into public comment, and we
12 plan to try to end somewhere around 2:30, 2:35, if at all
13 possible. All right?

14 Questions about the afternoon, or any other
15 comments from this morning?

16 [No response.]

17 Chairperson Hyde: Okay, terrific. So, you know
18 where lunch is, you got an extra five minutes, so we'll
19 start promptly at 1:00, not a minute later.

20 Thanks.

21 [Lunch recess at 11:45 a.m.]

22

1 [Afternoon session 1:00 p.m.]

2 Chairperson Hyde: Tom and Faye if you want to
3 come up, we'll get started. We'll give you about 10
4 minutes and we'll go from there.

5 Do you want to -- you can either sit at the table
6 and find a microphone or you can do it standing from over
7 there, whichever. But you do have to be at a microphone so
8 the people on the Web can hear.

9 Ms. Gary: Well, first of all I want to thank
10 Administrator Hyde and the other members of the National
11 Advisory Committee for allowing us to continue the dialogue
12 that we began on September 25th, 2009 when we were in
13 Portland, Oregon.

14 At that particular time, the members of this
15 committee thought that it would be useful if we were to
16 engage ourselves in some format, such as a workgroup, so
17 that we could begin, also, to have an in-depth, pithy
18 discussions about the kind of conditions that continue to
19 devastate the human and material resources of our Nation.
20 And from that, we had a discussion, and what we tried to do
21 -- what Tom and I have tried to do -- is take your
22 thoughts, your sentiments, and integrate them into a

1 document that would have some light, or some meaning, as we
2 begin to, again, in another year, look at the kinds of
3 health conditions, be them mental health, physical health,
4 substance abuse, social determinants of health, to put them
5 in some context that would reflect many of the
6 conversations that we've had over the several years, the
7 visits that we've done, you will recall that we went to the
8 Apache Reservation in Arizona. We started the dialogue
9 there, and again, when we were in Portland, Oregon, we
10 added to that dialogue. So this particular document
11 reflects your thinking and, in a sense, our editing of your
12 thoughts.

13 So, Tom and I listened with a third ear and we
14 took the data and we integrated the data into a framework
15 that Ms. Hyde had presented, and that is the four P's. And
16 we also have integrated into this document the ten
17 initiatives, and they are embedded throughout the document.
18 And I think at this particular time, since you have gotten
19 our version of the conversation. What is missing, now, is
20 your voice in response to the document that we have written
21 and distributed to you.

22 So, I think what Tom and I would like to do is to

1 ask you to respond to the document as you wish, and to make
2 comments that you think that would be helpful as we look at
3 the many kinds of challenges that we have before us as we
4 address the human condition and what we can do as a group,
5 as SAMHSA, as citizens, to move things forward and make it
6 better for all people.

7 Chairperson Hyde: So, Tom, do you want to
8 comment before we open the floor?

9 Mr. Kirk: Let me just add a couple of points.
10 One of them is that, is this on?

11 Chairperson Hyde: Yes, it is, you just have to
12 talk right into it.

13 Mr. Kirk: I think, just the point that I want to
14 add is that as a now-retired State Mental Health/Addiction
15 Commissioner, I'm very conscious of what States are going
16 through at this particular point in time. Extraordinary,
17 what I call, fiscal tsunami.

18 At the same time, the whole health reform agenda
19 is exciting, it's just where it is we need to go. And my
20 point is that, why we did this, I included in the document
21 what I thought were three major SAMHSA elements in their
22 portfolio that I see as critical to help us to get to that

1 next step. And then, so my counterparts -- wherever they
2 are, throughout the country, they do it -- and I have not
3 talked to anything about this, I truly believe that the
4 prevention initiative of the treatment -- substance abuse
5 treatment initiative, mental health transformation -- those
6 three documents, not so much in terms of content, but
7 rather their purpose, their methods, their funding ideas,
8 represent an extraordinarily transformative link to help
9 States get to healthcare reform.

10 SAMHSA is the mother ship, but where it happens
11 is in the States and communities. And from my point of
12 view, what you talk about here, and as you help SAMHSA move
13 on its mission, has to be in sync in such a way that as you
14 go back to where it is you go and you go back to Fairfax
15 County and the extraordinary hits you're taking, and then
16 Flo goes back to North Carolina, her legislators slicing
17 and dicing the budget -- we want you to be able to see
18 opportunities through SAMHSA to move this whole healthcare
19 reform agenda in ways that it's never been moved before.

20 So, but we want to hear what you have to say.

21 Chairperson Hyde: Okay, the floor is open, and
22 I'm going to be a little less controlling about who gets to

1 speak at this point. Before we were trying to stay within
2 an agenda timeframe. So, if you have something to say,
3 just jump in and just make sure you manage your microphone
4 so other people can hear.

5 Ms. Wainscott: I would just like to say, I was
6 really struck as I read this, and I will confess that I did
7 not have time to read it until I got here. But I was
8 struck by how well you had captured what you said last
9 time, and how there were not contradictions between that
10 and what we talked about over the last day and a half. I
11 was really struck by that.

12 Mr. Alexander: I wasn't necessarily struck, I
13 think I expected you guys to capture what we said in a very
14 -- in a good way. And also bring together with the ten
15 strategic initiatives, I saw that embedded, the four P's,
16 the ten initiatives that -- I did not read the entire
17 document, I didn't have time to. But, I guess, kind of
18 some of -- I kind of wondered what's next, what are next
19 steps beyond this. I know you -- we're losing you two, the
20 think-tank, motivator leaders. And I was just wondering if
21 you guys could leave us with, you know, where do you see us
22 beyond this document, having this document for guidance,

1 where do we take the think-tank beyond the production of
2 this document.

3 Mr. Kirk: Let me mention one thing, and I'm sure
4 Faye will add to this. Administrator Hyde mentioned
5 earlier today what I call, how do we connect the dots? All
6 of these different initiatives, how do we connect the dots?
7 And when you use the strategic prevention framework
8 platform that Fran Harding uses or mental health
9 transformation. Certain things were done in that that give
10 you the opportunity to try things that you never did
11 before.

12 So, for example, the Strategic Prevention
13 Framework, it requires that local communities follow the
14 five -- the logic model for prevention: local coalitions,
15 capacity, planning, and so on. You couldn't spend a dime
16 of that money, probably for the first 2 years, until you
17 did that. So, the whole essence of local coalitions --
18 which is where it happens -- had to be ingrained.

19 The same thing was done with mental health
20 transformation. It required the State to look at all of
21 the dollars that were being spent in mental health in that
22 State. So, you knew, it wasn't just the State mental

1 health authority, it was the full -- full ball of wax. And
2 how you come up with a plan to move to the next level.

3 Part of the point, Marvin, is when you look at
4 these things and you decide what will the portals be --
5 will it be to child welfare system? Will it be the prison
6 system? What part of the system do you want greater access
7 or responsiveness to? Those particular opportunities give
8 you a framework that you can use, a part of our message is,
9 as you go about your business, continue extraordinary
10 conversations during the last day and a half, look at those
11 models as ones in which, that's where we put it.

12 So, what Pam said before, how do you tie that --
13 this together? Those models represent an opportunity that,
14 in my last 10 years of dealing with SAMHSA, I think it is
15 an extraordinary change in ten years of dealing with
16 SAMHSA. I think it is an extraordinary change in the way
17 they do the business, and it is plus-plus --

18 Chairperson Hyde: Tom, just let me remind you
19 both, if you could talk right into that mic, it's hard --
20 it's hard for us and it's hard for the web folks to hear.

21 Ms. Gary: I'm sorry, was there a question? No,
22 you go on, did you want to ask a question?

1 Dr. Amaro: A wanted to make a comment.

2 Ms. Gary: No, you go on.

3 Dr. Amaro: So, I did read the document, I wasn't
4 at the last meeting but I was really impressed with the
5 quality of the document, of the thinking and the
6 articulation of the ideas and I found it very helpful -- I
7 particularly, really appreciated the conceptual frameworks
8 that you presented in terms of looking at the mechanisms of
9 action when one's thinking about health outcomes.

10 And I've been, you know, involved with SAMHSA
11 probably, I think since, you know, like almost 30 years, 25
12 years, and I think that for the most part both the agency
13 and those of us in the field have really been focused on
14 sort of individual-level factors that impact health. And I
15 think what the models point out is the important role of
16 the larger upstream factors.

17 And I know that I started talking about this,
18 earlier, Pamela, and that right after my comment you said
19 this could really grow and I sensed your being overwhelmed
20 by what I was saying. So, I wanted to come back to that,
21 because I do think that, you know, you asked, "What is
22 SAMHSA's role?" And in the articulation of what SAMHSA's

1 role is, it's not always just the funder, you know, it's
2 the convener, it's the partner with other agencies, et
3 cetera. And so, when we look at this model, it doesn't
4 mean that SAMHSA has to address all of these upstream
5 factors, but I think it would be essential that SAMHSA
6 participate with other agencies to also address the
7 upstream factors so that, you know, the old public health,
8 sort of, paradigm of, "Are you down the river pulling the
9 people out of the river, or are going to go upstream and
10 try and look at, you know, why people are drowning?" And
11 you have to do both, to some extent, but going upstream and
12 trying to address work in collaboration with agencies that
13 are addressing education, you know, community
14 infrastructure, housing -- all of the things we've been
15 talking about -- is really essential because those, you
16 know, they are some of the root causes of the problems that
17 we see in our clinical settings.

18 Ms. Gary: I think --

19 Dr. Amaro: I'm sorry.

20 Ms. Wainscott: Well, we had too much to say,
21 Faye.

22 Let me ask you a question.

1 Dr. Amaro: Sure.

2 Ms. Wainscott: I believe that when we started
3 talking about this, sort of, our motivating instinct was
4 trying to create a way for council members to be of more
5 use to SAMHSA, am I right in that?

6 Ms. Gary: I think as I recall, we first started
7 the dialogue because of the site visit that we had at the
8 Apache Reservation when almost every member of the Council
9 had their own editorial about what they saw on the
10 Reservation, and how things could be better. I think
11 that's one pathway.

12 The other pathway is that we also recognize that
13 Council members are very well-informed people, who work
14 every day in some aspect of what SAMHSA does, in substance
15 abuse, in academia, in research, in community-based
16 services, et cetera, et cetera.

17 So the other part of the dialogue, if you bring
18 together the magnitude of the problem and the resources
19 that SAMHSA has on its Advisory Committee, the question,
20 then, becomes how could these two interface to bring a
21 clearer, more succinct, more pithy, more integrated,
22 collaborative kind of approach to the massive numbers of

1 problems that we see across the United States and that we
2 label as substance abuse and mental health issues. So, I
3 think you are absolutely correct. But I think the
4 precipitating issue was the visit to the Apache
5 Reservation.

6 Ms. Wainscott: And it seems to me that our
7 challenge, now, because the environment here has changed
8 significantly with ten initiatives, some action plans is to
9 how to take that instinct to move ourselves in a more
10 productive way into the enterprise of SAMHSA, given what
11 really is a new and invigorated environment.

12 Ms. Gary: Yes, what -- I think that Tom and I --
13 and I just must say that Tom is a wonderful partner. Tom
14 and I talked on the telephone, communicated with emails,
15 and he was very -- aside from being very knowledgeable,
16 he's also very accessible. And I really appreciate that,
17 Tom.

18 One of the things that we talked about is the
19 four P's that are well-integrated into this document. And
20 also, the ten initiatives. And one assignment that I gave
21 myself, doing this -- our deliberations at this Council --
22 is to listen with a third ear to what Ms. Hyde said, to

1 what Ms. Power said, to what Dr. Clark said, to what Flo
2 said, to make sure that we were in complete harmony with
3 the initiatives as we heard them. And I have yet to
4 identify a source of conflict, I think they're all the
5 same.

6 What we've done is frame them differently, we've
7 organized them differently, but the problems are still the
8 same. The expressions of illness are still the same. It's
9 where we organize to get our work done that's somewhat
10 changed.

11 And I think that's okay. We don't -- if it's a
12 better way, we want it. Because actually we -- it's not
13 the organizational piece that is the focus -- it's the
14 outcome. We want people's lives to be better, we want
15 there to be a place in the community for everyone. And
16 that's what we are -- we are looking for those kinds of
17 outcomes.

18 And to be more specific, because I don't think
19 Marvin got an answer to his question, you said what do --
20 what do we think should happen next? Meaning Tom and me,
21 and I would also ask you, what do you think should happen
22 next, because you will be the one to carry the water,

1 because you're still on the Council.

2 But, I would like to propose an idea. Because
3 the Council, over the years, has been able to identify and
4 tap people who have expertise, national talents,
5 international reputations, et cetera. I was struck
6 yesterday, when Ms. Hyde was talking about the possibility
7 of regional offices, and I said to myself, and I whispered
8 to my partner, and I said, "What would happen if there
9 could be some organization around the country among
10 individuals who served on this Council who could get their
11 marching orders from Ms. Hyde, and do something in their
12 communities that represents SAMHSA's vision and SAMHSA's
13 mission and concretize it in such a way that would mean
14 that people in other communities would have immediate
15 access to some of SAMHSA's brilliance, some of SAMHSA's
16 materials, and feel connected?"

17 Now, I even thought about a little simple way to
18 do that. And it would be that Ms. Hyde or her designee
19 would write former Council members, asking them to
20 volunteer, send them all of Mr. Weber's fact sheets, and
21 say, "We want you to commit to having two Town Hall meeting
22 a year and a designated community of your choice. And we

1 simply want you to write us back and tell us what you did,
2 how you did, where you did it and what's your reaction to
3 it." And that's the SAMHSA program. It costs nothing but
4 a little time to send the email. So, that would be one way
5 of continuous engagement over the United States so SAMHSA -
6 - SAMHSA takes care of people who are invisible to many
7 others. Totally invisible to many others. And I think one
8 of the things that we could do, in addition to all that we
9 do, is to make these invisible people more visible, give
10 them a face and give them a voice, and we would ask people
11 that we know, who understand SAMHSA, committed to SAMHSA,
12 and love SAMHSA, to do that and be our Ambassadors in
13 different communities.

14 Mr. Gonzales: I -- if I may say something, I
15 don't know if I have any right to comment on the papers and
16 so, I'm a new member -- I think if SAMHSA buys the keg of
17 beer, I'll convene the Town Hall meeting, you know? That's
18 fine with me.

19 [Laughter.]

20 Chairperson Hyde: We might not -- we might do
21 lemonade instead of beer --

22 Mr. Gonzales: That's fine. Okay.

1 Let me mention something. I mean, I kind of just
2 briefly -- I looked at the Executive Summary and some of
3 the points, and it seems to me that what we discussed the
4 last couple of days is, as you said, Doctor, right on with
5 what your paper was talking about, there's no different. I
6 mean, it may be said differently, but all of the strategic
7 initiatives and everything that's being planned, with the
8 goals and everything seem to be task-oriented, evidence-
9 based environment, community involvement -- I think it,
10 there's no conflict, I think it's right on -- on target
11 with one another, both your comments and what Administrator
12 Hyde has been able to achieve in the past few months and
13 present to this Council.

14 I like the idea, though, I think some thought
15 needs to be given to how do you use the Advisory Council --
16 how do you use the Advisory Council as the eyes and ears,
17 if you will, like you say, and furthermore into the
18 communities. I think that that's really, really important.

19 For example, with your permission, Administrator
20 Hyde, I have a number of meetings coming up in the
21 community in New Mexico with the Health Policy Commission,
22 with the different Commissions that I've been honored to be

1 -- participate with. And it would seem to me, if it has
2 your blessing, I would try to get on the agenda in those
3 meetings, and try to say, "This is what SAMHSA's doing."
4 You know, these are the initiatives, this is what the new
5 direction -- not the new direction -- but the direction
6 brought together, you need to be aware of it, this is where
7 SAMHSA is going with the new leadership and communities are
8 to be involved, this is where the priorities are, and you
9 need to be thinking about that at your local and State
10 levels. I think that that's a role that I certainly don't
11 feel comfortable -- I mean, I certainly feel comfortable
12 doing that, I just don't want to step on anyone's toes or
13 misrepresent something -- which I usually do, anyway, but
14 what the heck.

15 You know, so I would -- that's the piece of this
16 document that I thought was real for me, anyway, kind of
17 lit the bulb and said, I just don't want to come to
18 meetings and -- I want to help in whatever way possible.

19 Mr. Kirk: Can I make a comment on that? Let me
20 suggest a reading for you. There's an article that was
21 done by a man named John Kotter, K-O-T-T-E-R, and it's in
22 the January 2007 Harvard Business Review. And I happened

1 to be looking at it and the essence of the article was
2 Kotter and his group looked at several, several major
3 companies, where the CEO came in and said, "We're going to
4 change the way we do our business." And he looked at what
5 were the elements that resulted, that were essential or
6 notable in those organizations that did a transformation.
7 The number one one was evident here yesterday and today.
8 The number one was not vision, it was a sense of urgency,
9 the sense of urgency. So, as you heard all of these
10 various presentations, it was a sense of urgency in each of
11 these different areas, that we needed to do something, we
12 needed to capitalize on the opportunities.

13 The second one, or maybe the third one, it ties
14 back to Arturo's point -- in my language, successful
15 projects have a thousand mothers and fathers, and the ones
16 that fail are orphans. And the more proper term was,
17 according to Kotter, there has to be a guiding coalition.
18 So, each of you, in the areas that you operate, you can be
19 part of a coalition to move the agenda along, because you
20 are respected people within your particular areas.

21 So, leadership at SAMHSA can do their thing, but
22 where is the guiding coalition that's going to continue to

1 move it along? And I think the kinds of suggestions that
2 you're making, Arturo, and others, Sophia, that's the
3 opportunity we have.

4 Ms. Cushing: Faye and Tom, I just wanted to
5 thank you personally for all of the work you've put into
6 this -- hours and hours -- on capturing the thoughts of the
7 Council members from two meetings and two different
8 settings and really organizing it in a way that not only --
9 it more than makes sense, it folds into Administrator
10 Hyde's strategies.

11 And I was particularly struck that you two were
12 just mentioning urgency, Tom, because that's one of the
13 things I highlighted in reading this paper -- the sense of
14 urgency to move to a new level of quality. And I was also
15 struck that you really mentioned a number of times the idea
16 of innovation. And how innovation can move us forward, can
17 drive things. And sometimes the Federal Government doesn't
18 exactly always support innovation. They want us to fit
19 into a box, and it's the people who -- the consumers and
20 the people in the trenches who force us to look at things a
21 little bit differently, and look at innovate ways to
22 approach things. Also, more cost-effective ways which you

1 mentioned a number of times in the paper.

2 There are a lot of things I'd like to mention,
3 I'm not going to take time to do so right now, I'll do so
4 later, but thank you so much for how you went about doing
5 this and what you've provided us, here.

6 Ms. Wainscott: Having been a member, I did all
7 that. I've told both Faye and Tom that, but I'd like to
8 say it publicly, too. Having been a member of a staff, I'm
9 very sensitive to the need not to overburden the staff.

10 But I think are at a place, now, where there is a
11 structure; I see two places where I want to help. And I
12 know who to call. And I think the guidance I've been given
13 is, email these folks, copy Toian, and go. We didn't have
14 that when this discussion started. But I do think we have
15 a place, now, if I'm reading that right, Pam, that that's
16 what you would like us to do. And I am intrigued by the
17 idea of an alumni association. These are people who have
18 given two, three or four years of their time to learn about
19 support and boost SAMHSA and it's unlikely that their
20 enthusiasm is less, but they don't have a venue, a way to
21 express it, and I think that's a fabulous idea.

22 Dr. Amaro: I wanted to say that I agree with

1 your suggestion. I think that SAMHSA could really benefit
2 from having as many linkages and arms out into the
3 community as possible.

4 Yesterday, I presented to members of the City
5 Council in Lawrence, Massachusetts, and to a group of
6 community members, and they asked me to talk about
7 prevention and treatment of alcohol and drug abuse among
8 Hispanics. And, it's a community that's 70 percent
9 Hispanic -- very unusual in Massachusetts -- with really
10 severe problems. And I presented many of the resources
11 that are available on the SAMHSA Web site, and nobody had
12 ever seen any of them.

13 So, I feel like there's this gap between the
14 wonderful, rich resources here and reaching the community.
15 People in the State agencies, you know, will know,
16 obviously, but the community members, really, I think, are
17 largely unfamiliar with the resources available. And if we
18 can play some role in improving that information -- even,
19 you know, so that we send out a -- uniform messages, you
20 know? A Power Point that we can all use about the messages
21 you want us to send out. We can be, like you said,
22 Ambassadors and -- the local connection, you know, to the

1 community.

2 So, I don't see a downside, right now, you know,
3 but maybe there's a downside that I'm not seeing. But, I
4 think would be very valuable.

5 Chairperson Hyde: Does anybody else want to
6 comment on this, if not, oh, yes, Ed?

7 Dr. Wang: You know, I just think that what both
8 of you demonstrate to me is that, you know, our work
9 doesn't stop here after the meeting. Both of you, you
10 know, took time outside of this meeting and come up with a
11 very wonderful, conceptual paper with some very rich extra
12 materials.

13 I guess the question is, then, you know, how we,
14 as the NAC, be helpful to SAMHSA. The direction is very
15 clear, you laid it out very well, starting with the term,
16 and then I think you also started with, then you have to
17 attain initiatives, you prioritize the first three.

18 The question I don't know, though, I think is for
19 other members and us to think about, is how can we be -- I
20 think suggestion being made, Ambassadors, making more link
21 directly with the community that many of us are in. The
22 question, really, is that how do -- how can we be helpful

1 and making that sea-change based on, you know, that ten
2 initiatives, particularly those three -- I think we need to
3 do something rather than -- at times I just felt like
4 coming to the meeting -- I learn a lot, definitely, make
5 some connections.

6 But I think we do have a responsibility at the
7 local level to make that SAMHSA name, the brand name out
8 there, based on those initiatives.

9 Chairperson Hyde: Well, if you -- if the --
10 George, do you want to make one more comment on that?

11 Mr. Braunstein: I just want to add my thanks to
12 both Faye and Tom for doing what they've done. It is a
13 nice -- it is an excellent document. I do think that the
14 establishment of a parallel set of indicators and goals
15 that were -- establishes strategic initiatives that have
16 been established by SAMHSA allows those of us who are in
17 leadership roles which, pretty much, is the National
18 Advisory Council to be able to link better with the work of
19 SAMHSA than we have in the past. And I think that's going
20 to be, in and of itself, excellent. And I -- I saw this as
21 our effort to reach out and find a way of being more linked
22 and helpful on an ongoing basis and not seeing -- or

1 seeing, or not seeing our roles end at the end of each
2 meeting. And so, I think this -- this is an excellent
3 document, but as important is now I know what you're
4 working on, who you're working on it with and it gives me,
5 now, a sense of how to link in to SAMHSA when I want to
6 offer to be of assistance, or get involved beyond the
7 meetings.

8 Chairperson Hyde: Great, so let me make just a
9 comment or two. And Tom and Faye, thanks. This was not
10 only a good paper, but it generated yet another good
11 conversation, so thanks. You don't have to stand up, you
12 can sit, you can do whatever, we don't want you to just
13 stand there, so --

14 Mr. Kirk: Can I just add -- just one point?

15 Chairperson Hyde: Yeah.

16 Mr. Kirk: Westley talked yesterday and I think
17 Pete Delany talked yesterday about need and all sorts of
18 people who are in need of service that are not getting it.
19 One of the striking things about access and recovery is
20 that you gave grant awardees the flexibility to use dollars
21 in a different way.

22 And just two quick examples: Women coming into

1 treatment are underrepresented and if you look at those who
2 run systems around September, it's the lowest point of
3 entry for women into the system. One of our researchers
4 said something, "Let's try something," and what they did is
5 that they said, "Let's allocate money to buy a backpack for
6 the kid to go to school, a decent pair of pants, an outfit
7 for the child to go to school." That was more engaging in
8 bringing women into treatment than for us to say, "We can
9 give you an appointment on Monday." "We can't go Monday,
10 my kid's going to school." And as simple as it is, it cost
11 us a hundred bucks, something like that, that type of
12 thing.

13 The other point, I'll go back to Marvin's point,
14 it allowed us to provide recovery support services to
15 people we never saw before. Forty percent of the persons
16 that were brought in out of the 18,000 we'd never seen in
17 the system before. The didn't come because we were
18 suddenly offering treatment, they came in because we
19 offered them personal care items that we would say, "We'll
20 pay a month of your rent as you try to get stable." Those
21 are things that SAMHSA put into those efforts that were
22 innovative, flexible and gave us the opportunity to do what

1 we needed to do. I had never seen that before.

2 So, the kinds of things you talked about and the
3 challenges, those are opportunities in the framework, the
4 way SAMHSA has done its business over the last several
5 years, you need to take the opportunity to look at the
6 prevention pieces, the mental health transformations, both
7 of those are changing the whole infrastructure of the
8 service system, they were not services -- a grant. But the
9 process, to go about it, there are all sorts of great
10 things going on in Missouri and other places, tying primary
11 care with mental health. We need to be about those.

12 So, it is happening, and we just think that,
13 everything you've talked about for the last day and a half,
14 it's there, but how do you move to the next level? I would
15 urge you to look at these things and see how you tie it
16 into that framework.

17 Chairperson Hyde: Okay, great, thank you.

18 Let me make a few comments and then we all, we
19 have time for a little bit more discussion back and forth.
20 There's kind of two things on the table right now, I think,
21 by virtue of the paper. One is sort of, what else can the
22 Council do? Or how else can the Council serve? Or how

1 else can you be helpful and effective in helping move the
2 agenda, et cetera. That's one set of issues.

3 And then the other set of issues that I think the
4 paper raises is just this, sort of, fundamental, how do we
5 move positive behavioral health services and systems
6 forward, which is a much bigger sort of conversation.

7 All right, let me say a couple of things, in some
8 ways wrapping back around to where we started yesterday in
9 which I did two things. One is, I talked about SAMHSA's
10 role, and the other thing I talked about is my view of
11 Advisory Councils. And so, let me do that again, just to
12 remind you and then have you react, given the day and a
13 half that we've had.

14 There is a -- if I remind you -- there's a piece
15 of paper, if you don't have the single sheet, this same
16 material is actually in the fact sheet at the beginning.
17 It's about SAMHSA's role. And to remind you, part of the
18 reason I -- we, collectively put that together is because
19 very clearly, early on it became clear to me that people
20 viewed SAMHSA as primarily a grant-making entity and
21 weren't seeing, as much, our role in leadership, in policy,
22 in being the behavioral health voice for the country in the

1 communication efforts that you heard Mark talk about
2 yesterday, sort of the branding issues, those kinds of
3 things. Didn't see as much -- even though SAMHSA does it -
4 - but didn't see as much the role in convening and
5 collaborating in just trying to identify what the issues
6 are and trying to get other systems to move in setting
7 standards and improving practice, you know, just all of
8 those other things that SAMHSA does. So, one of the things
9 we tried to do is just, literally, write that down, in a
10 simple and easy way that people could see.

11 So, part of these materials we're trying to
12 develop are just exactly for that, to say, yeah, SAMHSA
13 gives out grants, and it's a dang good thing we do. But,
14 it's more than that. And there are other things we can do.
15 And part of the reason that's so important, frankly, right
16 now -- because the paper mentioned it and it's certainly
17 been part of my stump speech for awhile, here, which is
18 we're focusing on people, but we also have to take
19 advantage of the opportunities. And on some levels, you
20 can look at the opportunity right now to make lemonade out
21 of lemons, which is, we don't have a lot of money, and
22 there's not going to be a lot of new money in the next

1 couple of years, by virtue of the budget stuff we talked
2 about yesterday.

3 So, how can we use either the current money that
4 we have, kind of shifting it around, doing it together,
5 doing it with other departments, braiding it, focusing it,
6 whatever you want to call it, to make the most of those
7 dollars and engage the States, as I talked about yesterday,
8 and how do we think about the block grants versus the
9 programs where we're trying to identify new models, and
10 when is it appropriate to bring something into a block
11 grant because we've now proven that it works and we want it
12 everywhere. As opposed to just one or two or ten or thirty
13 grantee places. So, some of that kind of conversation.

14 And then, also, to the extent that there's not
15 going to be new money, if that's true, if it's true that
16 it's hard to get new money in the next couple of years, how
17 can we use some of these other roles that SAMHSA has to
18 continue this dialogue, like the stuff that John O'Brien
19 talked about yesterday and trying to make sure that we are
20 -- I call it, he didn't call it this -- but I call it
21 leading by nuisance, sort of just, being everywhere, you
22 know, being in their face, being, you know, "Hey, what

1 about behavioral health? Hey," you know, just being there,
2 talking it up, doing it, et cetera, so there's a little bit
3 of leading by nuisance that we're trying to do in all of
4 these areas. And, you know, to not be quite so silly about
5 it, we're being very welcomed, I think, at all of those
6 tables. So, that's a good thing.

7 So, role is important, especially as we look at
8 the opportunity we have may not necessarily be a money
9 opportunity, it may be a opportunity to sit at the table.
10 And again, I think military families is a great example,
11 because Kathryn has been able to move things, as she said,
12 by just being at a table that no amount of money -- because
13 we don't have a whole lot, to put to it is going to let us
14 do right now. So, thinking about those kinds of things and
15 your input about that is useful.

16 So, let me say just a word about, again, repeat
17 slightly, but expand a little bit on yesterday's comment
18 that I started with, which is that advice is product, and
19 you have just given us a huge product in the last day and a
20 half. I have notes, we have tons of perspective, we have
21 different information, we understand where you're
22 interested that we can pick your brain, or you understand,

1 now, where -- as somebody said -- who's leading on what and
2 how you can provide input.

3 So, just the fact that you've sat here for a day
4 and a half and participated with us in these rich
5 conversations, which is exactly why, to me -- I've been on
6 Advisory Committees, it is boring to sit and listen for a
7 day and a half if you don't get any chance to interact or
8 figure out, what does this mean and what's the point of me
9 being here? So, hopefully, this day and a half has let you
10 feel that what's in your minds and hearts and knowledge and
11 experience is truly a product to us. And we appreciate it,
12 and we've extracted a lot from you.

13 We also are very aware that all of you are very
14 busy people, just as we are. So, that's why having you
15 here for a day and a half and making the most of your time
16 and your heads and your hearts is important. And at the
17 same time, not wanting to ask more of you than you signed
18 up for.

19 So, some of you may feel like you really want to
20 do a whole lot more, and if so, we'd like to take advantage
21 of that. But as a group, we're not -- we didn't come into
22 this expecting to have you meet a bunch more times, or have

1 you do a bunch more stuff when you get back in your
2 communities or whatever. And I'm saying that just for
3 those of you who really can't, for whatever reason -- don't
4 feel like this conversation is expecting you to be anything
5 more than you signed up for.

6 So, now, having said both of those things, you
7 know, there's been a couple of intriguing thoughts. One of
8 this whole concept of an alumni association, how we could
9 use people who have been around this table before but,
10 frankly, didn't hear this conversation. And how do we get
11 them up to -- if we were going to do that, how would we get
12 them up to speed on all of this without taking more time,
13 money, et cetera, because frankly it does cost time and
14 money to interact with big groups of people. So, how do we
15 do that, if that is really something that sounds like it
16 might be worth pursuing in some way, so hold that thought.

17 And then, but this idea of you all going back and
18 using the materials that we've produced for -- because you
19 all have different opportunities -- you've got a radio
20 show, somebody else has got an opportunity to sit in front
21 of a group at a city council or whatever, so how do we use
22 those opportunities just for you to do what you want to,

1 and what you're able to, without, you know, expecting that
2 you can do, or will do, something that you don't have time
3 to do or can't.

4 I think, given that I've said two or three times
5 that we're working on a paper, trying to -- really trying
6 to bring all of this stuff together, and every time the
7 leaders present, then the paper has to be changed again,
8 because we're always evolving, that's part of the fun of
9 this.

10 But, nevertheless, very soon we're going to have
11 a paper that will be in draft. And one of the things that
12 we could do is ask you if you're willing -- maybe a little
13 bit around Faye's theory is pick two things, two people,
14 two groups, that you would like to take that paper to and
15 say, "What do you think?" And if we did something like
16 that, I truly think it would be on your time, on your
17 timeframe, on your -- in whatever way you can do it, and
18 without expecting any of you to do it if you can't. So,
19 I'm trying to balance, here, the expectation that you will
20 do something more than what we've asked of you and yet at
21 the same time, take advantage of anything you are willing
22 to do to be helpful.

1 The other thing is, I really want to comment
2 about, I think it was George or somebody that said, "Now
3 you know," or maybe Cynthia, "Now you know who's working on
4 what," we really do have leaders on these things for good
5 reason. I sure as heck can't lead them all, either by time
6 or by content. And we have asked each one of those leaders
7 to carry the whole Administration's information and water
8 about that.

9 So, just because it's Westley on one thing
10 doesn't mean that one's about substance abuse and Kathryn's
11 on something else, and that one means it's mental health.
12 They are leading, and so is all of the -- are all of the
13 other leaders, on everything. So, if you're not sure where
14 to go, or you don't know how to think about, well, what's
15 SAMHSA doing about this? You can go to the leader in that
16 initiative and they can help you navigate within SAMHSA
17 what we're thinking, or what we're trying to do about those
18 issues. So, if you want to participate on just one
19 initiative, or you want more information or want to provide
20 more help, or want them to have whatever.

21 If you wanted to go out and do just one thing
22 about trauma, and that's all you wanted to do, I think

1 there's ways that you could do that, as well.

2 So, those are just some reflections about both
3 what your roles could be, without expecting or demanding
4 that your roles could be more than what you're able, and at
5 the same time wanting to be as appreciative as I can
6 possibly be about what we've done in the last day and a
7 half together, already.

8 So, let me stop and see if you have any reaction
9 to that, and then we'll go to the next item.

10 Dr. Amaro: I was thinking that, also, maybe some
11 mechanism that's easy for us to communicate, some kind of
12 web-based mechanism where, for example, the documents from
13 these meetings can be put, you know, the slides, et cetera,
14 and some kind of communication can occur between us, you
15 know, just to keep each other updated, would be useful.

16 Chairperson Hyde: Well, let us -- that's good.
17 I -- you heard yesterday one of the things we're trying to
18 do is consolidate some of our Web sites, and our Web
19 content, and so I don't know what the mechanism is, but let
20 us talk to the communication people about whether or not
21 there's a way to have sort of an internal conversation that
22 you can have, or a way that you all can have information.

1 A lot of these documents are on the Web,
2 SAMHSA.gov, and they're being updated as we update them, so
3 just to the extent that you want to use any of them, pull
4 them down and use them, you're welcome to do that. Some of
5 that's just in the public domain, even in draft form. But,
6 we'll pursue whether there's some way to do that kind of
7 communication. Obviously, in the meantime, I guess email
8 is one way to do it, but that's not always quite as
9 efficient.

10 So, okay, other comments or thoughts about any of
11 the content you've heard over the last day and a half? Or
12 this, sort of, the richness of this discussion about moving
13 the system forward, or your role? You also have a right to
14 get on the plane and think about it for a little while,
15 because we've pulled a lot out of your heads in the last
16 couple of days.

17 Any of the other SAMHSA -- the Center Directors
18 are all here, any of you -- three of you -- have any
19 reactions or thoughts?

20 George?

21 Mr. Braunstein: This is kind of -- kind of a mix
22 of thoughts, maybe, but this is probably the only meeting

1 or series of meetings where I'll sit this still for this
2 long. Maybe I should be on Ritalin or something.

3 But what -- I always -- I have a sign in my
4 office which is based on an old saying, "Is the juice worth
5 the squeeze?" And I really try to make sure that my time
6 is spent on something where I feel I can make a
7 contribution. I ask that question when people ask me to
8 join Boards, I ask that question in any number of venues
9 and when I'm asked to be a participant in something.

10 I get a sense -- and it's not that SAMHSA -- the
11 SAMHSA leadership who have been here for a long time
12 weren't doing some really great things, because I've seen
13 some of them in action, it's that -- from a strategic
14 sense, which is how I tend to think about things in my
15 level now -- this pulls together, and it pulls together
16 what kind of -- it feels more like it's the HHS or even the
17 Federal Government pulled together of where things are
18 going, so it doesn't feel like SAMHSA is just doing their
19 own thing and it doesn't feel isolated. There's a -- there
20 aren't a series of isolated initiatives, they're all kind
21 of connected, because I could see the connection between
22 all of the initiatives and how they -- they link.

1 That being the case, then to answer the question
2 -- I could see things coming out now where it would be
3 worth my while to respond, participate, assist with getting
4 inputs, whatever it was that you were looking for and use
5 whatever connections I have to get the word out. And it
6 would feel a whole lot more like -- that there was a
7 contribution to make, even through advice that would
8 possibly enhance it. Because I can see the vision, or I
9 can see the strategy and where it's going, and I didn't
10 always see that. And it's not just here -- I've got the
11 same issue with my own State. A lot of times, I'm not sure
12 where the hell they're going.

13 So, basically, the bottom line is I really do
14 think that there is a value to being available more than
15 just two times a year and being able to be a participator
16 that way, or an advisor, if you will.

17 Chairperson Hyde: Okay, any other thoughts or
18 comments on these roles or the paper, or anything of that
19 nature, at this point?

20 Well, let me move us on, and it may carry the
21 conversation a little further, but let me shift your heads
22 a little bit. We do need to talk a little bit about next

1 steps. Although there is a topic on here called, "Any
2 other interests of the members," is there anything that
3 we've talked about in the last two days that you think
4 we're missing? Is there anything that you think is really
5 something, or you want to know what we're doing about "X"?

6 Ms. Wainscott: I think I didn't make myself
7 clear because I wasn't clear in my own head about
8 something, and as I've had time to think about it, as a
9 result of Pam's very skilled inquiry and I really -- that
10 is a compliment I want you to absorb. You have inquired of
11 us, you have gotten things out of us that I don't believe
12 the average facilitator would have gotten out, thank you.

13 But, on the SBIRT -- I think I was almost
14 unwilling to engage about it, because I don't want to be
15 negative about it, I don't want to pick it apart. For one
16 thing, there are members of the Council who would hit me if
17 I did, but also because it's an important thing.

18 I also didn't want to reinforce, and don't want
19 to reinforce, the separation of mental health systems and
20 substance abuse systems. That's, actually, fatal
21 sometimes. But, there are 55 counties -- I learned that
22 from one of the slides -- that don't have a mental health

1 practitioner in this country. In Georgia, we have 100
2 counties without a psychiatrist. Healthcare reform is
3 going to add -- and these are all, these are talking points
4 I'm walking away with -- healthcare reform is going to add
5 2 million new clients on top of the existing 23 million
6 treatment gap. Yikes.

7 That doesn't mean intervention -- brief
8 intervention and referral is unimportant, in fact, I think
9 it's critical to sort of making clear that there is a
10 market for this. But the thing I would like to advocate
11 strongly for, here, is some kind of real focus on helping
12 the doctors be better prepared to do what they are going to
13 do in general practice offices, which is to take care of
14 the people that don't get to the specialty providers once
15 we identify them. It's the age-old question -- we did the
16 same thing when we started educating about depression --
17 don't be afraid to educate because we're not ready, but
18 remember that we're not ready and work on that at the same
19 time.

20 Sort of as a p.s., I really endorse the idea of
21 us having access to these materials in some way that's easy
22 for you and for us. This fact sheet is fabulous, and I

1 couldn't write fast enough to get all of the updates that
2 were provided there, so maybe --

3 Chairperson Hyde: We'll try to make all of these
4 presentations available on the Web. Because there's some
5 facts in the presentations that aren't on the fact sheet,
6 that's how come we keep updating these, but we'll try to
7 make sure that they're all available.

8 That's great, good input, thanks.

9 Dr. Amaro: Just regarding that, I know that you
10 said some of these are available on the Web, but we'd have
11 to go looking for all of them, and it would just be helpful
12 if they were sent to us.

13 I did have a question about the 5 percent -- was
14 it 5 percent set-aside for women's services on the block
15 grants? Does anybody remember that? Okay. So, I'm
16 wondering whether you have any information on the extent to
17 which that's really being kind of held to by States?
18 Because a number of people who have looked at it in
19 previous years have said that they feel like that's really
20 -- I think Chris Grella from UCLA did an article some years
21 ago discussing the fact that a lot of that had kind of
22 eroded and, you know, fallen away, and I'm wondering what

1 the status is of that?

2 Chairperson Hyde: Let me see if any of the
3 Center Directors want to respond to that. We do have a
4 group that works, just explicitly, around women -- women's
5 -- women -- issues for women and girls. And I've met with
6 them, they're a group of advisors or folks working with us.
7 But, do you guys -- any of the Center folks have, off the
8 top of your head, information about women's issues in the
9 block grants?

10 Ms. Power: The Mental Health Block Grant doesn't
11 have a set-aside for women, per se.

12 Dr. Amaro: The substance abuse --

13 Ms. Power: The Substance Block Grant does, and I
14 --

15 Dr. Amaro: I wonder if it is being used that
16 way.

17 Chairperson Hyde: Westley, I think, is looking
18 to see whether he's got that information. We can get that
19 information. We just don't have it here, maybe.

20 Dr. Clark: I was also looking at our
21 discretionary portfolio and it appears that women are
22 fairly well-represented in terms of the percentage -- more

1 than the 5 percent. So --

2 Chairperson Hyde: Let us get you that
3 information, it's a specific question we can get an answer
4 to you for. An answer for you.

5 Dr. Clark: It's 33 percent of the people seen in
6 the block grant are women. So, but you're talking about
7 specific -- gender-specific services?

8 Dr. Amaro: Yeah, I think it would be worthwhile,
9 because it was a lot of effort to put that kind of
10 requirement, some time back, and my understanding from
11 talking to people in the field is that that's sort of been
12 slipping, and we might want to look at whether States are
13 really setting aside that portion of the block grant monies
14 for women-specific services. Or how they're using it.

15 Dr. Clark: Yeah, we can get the --

16 Chairperson Hyde: We just don't have it here,
17 but that's a good question.

18 Dr. Clark: But we do know that 33 percent of the
19 clients seen with the block grant are female. So, now, the
20 specific treatment modalities, we would have to get that.

21 Chairperson Hyde: Yes, Flo?

22 Ms. Stein: I know that SAMHSA looks at that in

1 the core reviews. So, the core reviews should say exactly
2 what each State is doing and how they're meeting that
3 requirement.

4 Chairperson Hyde: Well, again, we have the
5 information, we just don't have it here, in this room.
6 We'll get it for you. Yeah.

7 Mr. Gonzales: One of the things that I need some
8 help with, I think, you know, this Ambassador idea, I like.
9 But we've got to have, I don't want to misrepresent what
10 things mean. When I look at the Fiscal Year 2011 budget
11 expansions or whatever for community prevention, you've got
12 increases in access to recovery, increases in screening to
13 brief intervention, referral to treatment, increases to
14 suicide prevention, specifically the Garrett Lee Smith
15 Memorial Act. And these are all programs that, for me,
16 affect the State that I live in.

17 So, when I go back, you know, and we're having
18 fiscal problems in our State, and this becomes public
19 information, then I don't know how to respond, "Well,
20 what's the problem with SBIRT in New Mexico when there's
21 going to be an increase in screening in Federal grants for
22 referral monies?" The specifics of what that means is not

1 clear to me. And I don't think I need to have the answer
2 now, but at some point does that mean new programs are
3 starting? Does that mean access to recovery in New Mexico
4 continues for another year? You know, that's what I mean
5 by not misleading.

6 And Dr. Clark could be helpful with this at some
7 point. But what does it mean for the future of those
8 programs that have been established in those -- in some of
9 the States already?

10 Chairperson Hyde: Actually, that's a great
11 question and let me answer it generally, but then again,
12 the Center Directors may have more specifics.

13 In almost every case in budget increases, unless
14 it is an increase to the block grant, which does go to
15 every State and then the States make some decisions within
16 our parameters on how those things are spent -- unless it's
17 that -- so, if it's in the discretionary portfolio, which
18 they all are. All of the budget increases, I believe, are
19 in the discretionary, right? What that means is that
20 either we give additional grantees money, so it may have
21 nothing to do with a particular State, or it means grantees
22 continue another year. So, it's not -- it's not like it's

1 national -- if there's \$6 million more in the children's
2 portfolio, that doesn't mean that any one particular State
3 or all States get more money for children. It means
4 there's more money for Systems of Care Grants. That's what
5 that means.

6 So, am I saying that right, guys? So, any other
7 comments about that?

8 Ms. Power: Well, I think there is a way that we
9 can provide information to the Council members, you know,
10 about the budget that, I think, is useful. And we should
11 be able to help you answer those questions when you are
12 called upon to do that. In other words, there are profiles
13 of the Federal money that go into the States under the
14 SGENS program, and you can have all of that information,
15 Arturo, that would at least be able to help you answer
16 those questions about what the distribution of a particular
17 budget dollar looks like.

18 Mr. Gonzales: And the reason I ask that is
19 because I know that with the crisis that States are having,
20 and particularly our State, there are groups getting
21 together to talk about programs that have been funded by
22 SAMHSA that might be working, maybe, you know, whatever,

1 that they want to keep. And, how do they do that? You
2 know, they're going to ask the question, how do they do
3 that, because they see that as potentially very beneficial
4 with the State budget, and when they see this they say,
5 "Oh, maybe this is the way we do it." But maybe it isn't
6 the way you do it. And that's why I need the --

7 Ms. Kade: We do, every year, develop a summary
8 of the budget and one aspect of that summary is we
9 articulate, we actually line out where there are new
10 funding opportunities. So, we translate the budget
11 increase into new funding activities. And, as soon as we
12 end this meeting, I'll run upstairs and get you our little
13 foldout and it will actually walk you from the additional
14 funds to the new funding opportunities. And we also
15 formalize that and publish a list of new funding
16 opportunities, along with the Department, but that happens
17 later on.

18 Chairperson Hyde: So, if you've got time to
19 stay, she can get you a copy of that now. Otherwise, we'll
20 get that out to everyone, as well.

21 Mr. Gonzales: Okay.

22 And not to beat a dead horse, here, or a horse of

1 a different color --

2 [Laughter.]

3 Mr. Gonzales: Senior moment, here. Senior
4 moment, here. The feedback might be to the -- from the
5 constituents if, for example, in a case like this, if it's
6 for new grants and not for continuation of grants, there,
7 the feedback from the community might be, "Well, why isn't
8 it for continuation of grants?" You know, and to bring
9 that feedback back to SAMHSA may be very important for
10 reconsideration.

11 Ms. Power: And I also think that, as the
12 opportunities roll on in terms of grant programs coming to
13 an end, that's usually an answer for why there is no more
14 money or if there's new money in it, you can then encourage
15 people to apply for their new money, and then there will be
16 new RFAs , as Darryl indicated. So, these past two weeks,
17 we've put out a number of requests for applications and I
18 would hope that New Mexico would know about those and would
19 be applying for them and the place-based initiatives, the
20 CRRRI initiative, all of those are new opportunities,
21 frankly, given the state that the States are in for
22 applying for some of those grants. And hopefully there

1 would be a combination of that kind of work that the group
2 is talking about, where they get together and strategize
3 what would be the best opportunity to go after for new
4 money.

5 Chairperson Hyde: Although this issue, Arturo,
6 I've sort of mentioned it in passing a couple of times, but
7 let me just say it again -- I continue to find it a dilemma
8 that when we are given these dollars to do special
9 programs, it's not enough money to give the whole country
10 what we know it needs. It is enough money to fund 20
11 communities, or 20 grants, or 10 applications or whatever.
12 And we are always struggling with those 10 run out of the -
13 - it ends for them after three years or four years -- is it
14 fair to keep those 10 going and give nobody else an
15 opportunity? Or do we give other grantees an opportunity,
16 and this issue of going back to the States for
17 sustainability is a huge issue, especially right now.
18 Which is part of the reason, frankly, I want to engage the
19 State more, right up front, in who's getting grants and
20 who's going to be coming to them asking to continue, et
21 cetera for exactly that reason, because the States are one
22 of the primary sources -- they're not the only source, but

1 they're the primary source where a grantee that runs out of
2 money from us is going to go to for sustainability, that
3 either the State, per se, or the legislature, one or the
4 other. So that these are -- this is a dilemma for me,
5 anyway, I think it is for Center Directors, as well.

6 Yeah, Wes?

7 Dr. Clark: There are two things. One, when a
8 grant is awarded, essentially the next day we start talking
9 about sustainability. So that the grantee knows that
10 that's a critical issue, whether it's a 3-year grant, or a
11 4-year grant, or a 5-year grant. The two -- it's an open
12 competitive process, which means that an existing grantee
13 may have an opportunity to recompetete.

14 But there's a third thing that we should also
15 keep in mind since you're looking at the role of a Council
16 is that we're in this transformational period. By 2014, we
17 may have resources for a whole new cohort of individuals
18 using strategies that, hopefully, some of these grants will
19 have helped to develop. And so, what we'll be moving off
20 the table is the status quo, because we'll have developed
21 those new strategies. And so if there are discretionary
22 funds available, then the question is, what should those

1 funds be used for? But the other question is, what are the
2 States going to use the new monies, if you will, as they
3 will play a role in monitoring providers and determining
4 what kind of services are available and working with CMS
5 and SAMHSA, et cetera.

6 So, this is not your usual period, even though
7 States are taking a beating economically at this juncture,
8 by 2014, the whole paradigm will shift. And so, we won't
9 simply be relying on SAMHSA as a safety net, we will be
10 able to tap into healthcare reform resources to deliver
11 services.

12 So, then the question is, what will those
13 services look like? How are we going to account for those
14 services? How do we establish accountability for those
15 services? So, we have a lot on our table. So, this is
16 probably an exciting time for you to be on the Council.

17 Chairperson Hyde: Yeah, this goes back to John's
18 point about, we're going to have stop, in some ways,
19 looking at grants as the way to fund things. We are,
20 frankly, going to be looking more at Medicaid and
21 commercial insurance and some other things and then, so
22 defining benefit packages is going to be a different issue

1 than coming up with a grant program.

2 I do need to move us to the conversation about --
3 every time we get going on a good conversation I have to
4 move us -- to what next, and where we're going to meet
5 next, and what you'd like to be on that agenda next. My
6 assumption is, from having heard from ya'll earlier that
7 you would be appreciative of sort of a little bit of
8 update, if not the whole meeting, but certainly some update
9 about where we are with these ten things. Is that fair to
10 assume? Okay. And we'll think about how best to do that,
11 and given your various and sundry interests in this, we
12 might even be able to come back to you ahead of time and
13 say, "Would you participate in this particular one?" So
14 you can learn a little bit more about that one, and then
15 actually it may be -- help present or help work with us on
16 that.

17 The other question is, where? We can meet here
18 again, we can meet somewhere else out there, I understand
19 the Council has met in Phoenix and Oregon in the last
20 couple of times. So, it's your call. We made an explicit
21 decision to meet here this time -- for lots of reasons.
22 But we don't have to do that. We can meet somewhere else.

1 So what is your thoughts about that? If we did meet
2 somewhere else, it would probably not be that west,
3 probably some -- it would be in the middle of the country,
4 or the Northeast, or the Northwest, or the South or
5 something like that.

6 Ms. Cushing: A number of Council members have
7 extended invitations to the Council to meet in their
8 cities, and I know that one of the first to offer was
9 Cynthia in Atlanta, and Boston, and Ed in Boston. And I
10 think there's great value in the Council, seeing programs
11 and services on the ground, at work -- the challenges and
12 all that's going on across different populations and
13 different settings and certainly different parts of the
14 country, that's an education in itself. And I would just
15 suggest the Council, you consider meeting in another
16 location the next meeting, or maybe alternate or something.

17 Chairperson Hyde: Clearly another location is a
18 definite possibility, I've heard Atlanta, Boston, I'm open
19 for other thoughts about that. It's not just location,
20 though, for me, I've gotta be honest with you. We have 10
21 initiatives, that's what we're working on. If we're going
22 to meet somewhere else, I'd really want it to be in a place

1 where we could focus on specific, either, information or
2 program or something that gives us some more information or
3 shows us some more about what either is or isn't working in
4 terms of the way we're trying to move these 10 initiatives.
5 So, if anybody has thoughts about that, I'm open for that.
6 Did I see Stephanie's hand?

7 Dr. LeMelle: Well, I actually was going to ask
8 you that point, that is our traveling around the Nation to
9 travel around the Nation? Or is, you know, was it more
10 targeted towards specific projects? And I think if that's
11 the case -- it seems to me that since we have such a
12 limited time as a group together that we probably do want
13 to use our time wisely. And that maybe picking sites that
14 have specific programs that we'd want to get more
15 information on, and maybe not even programs that we already
16 know about, but maybe something new that we don't know
17 about, would be useful.

18 Chairperson Hyde: Marvin?

19 Mr. Alexander: I just wanted to put in a plug
20 for Atlanta and Rising Carter -- I hear that every time I'm
21 here, something about the Rising Carter Center. And I know
22 that you met, here, Mrs. Carter, and I just thought maybe

1 that's an appropriate trip. Not to say Boston wouldn't be,
2 Ed. But -- that's a plug.

3 Chairperson Hyde: I see a different -- Ed?

4 Dr. Wang: I actually -- going back to your first
5 question and I just wanted to make a plug on this one, is
6 that -- first of all, I agree that I think it has to be the
7 initiative-specific in terms of the location. But, I want
8 to add a component of this, is that one of the real cross-
9 curring areas, it's really -- in terms of, you know,
10 equitable care as well as quality of care, it's a cultural
11 and linguistic competence.

12 So, what I would like to see is that those 10
13 initiatives -- because it is cross-cutting, and I hope that
14 the leads of those 10 initiatives will really pay some
15 attention to, as part of that initiative to specifically
16 focus in terms of various cultural, ethnic, linguistic, age
17 populations and so forth, is cross-cutting. So, I think
18 that's one thing.

19 The other thing I just want to mention is that,
20 you know, in-house you have some very excellent success
21 kind of foundation already established, both in terms of,
22 you know, the national network to eliminate disparities in

1 behavioral health. I think that's one group. I think the
2 other group is CMHS has the, you know, eliminating mental
3 health disparities -- just a lot of work has been done.
4 And I'm just wondering, just want to make sure that, you
5 know, because it is cross-cutting, and that piece is not
6 going to be missed in regard to the ten initiatives,
7 because I think they can offer a lot.

8 And the network is tremendous -- both here, in
9 terms of SAMHSA, all the way down to the local level. And
10 as a matter of fact, the EMHD workgroup just met here a
11 month ago, I think they are, actually, putting together a
12 letter to you, Administrator Hyde, to reflect in terms of
13 the outcome of that meeting.

14 So, I think this is a great opportunity, just
15 like what we have talked about opportunity, is to really
16 that issues of equitable and quality of care.

17 Chairperson Hyde: Flo?

18 Ms. Stein: I just wanted to put in a plug for
19 here, because I thought one of the things that made this
20 meeting really successful was the availability of all of
21 your staff and your partners. And I think, right now,
22 because of health reform, the Federal Government in

1 relationship to the States is really where all of this
2 transaction is happening. And so, I think that's really
3 valuable to get to see what you're doing.

4 Chairperson Hyde: Okay. I see Don and then
5 Hortensia.

6 Dr. Rosen: I could go either way. If we do go
7 somewhere, I was thinking, Massachusetts recently
8 implemented healthcare reform where they had to ramp up
9 from a significant uninsured population to bring them into
10 the insured pool, and we might learn something from how
11 they did that.

12 Dr. Amaro: I really like the idea of -- and
13 found it valuable when we've gone to visit program to learn
14 about what's not happening, or what is working, and with
15 that in mind, I would favor either Massachusetts for the
16 reasons given, in terms of healthcare reform and looking --
17 what we're learning from that.

18 The other place, thinking kind of very
19 differently, is New York because I particularly would be
20 interested in the Harlem Children's Zone and that whole
21 huge project that is really, I think, a great model to look
22 at that helps us kind of pay attention to the upstream

1 factors that are in the model that we tend to get
2 overwhelmed with because we're not -- haven't focused on
3 those.

4 And the third would be, another angle would be to
5 go to one of the territories, like Puerto Rico, which is
6 the most accessible one, to look especially at the issues
7 of the Medicare problems and the limitations in terms of
8 the benefits that they receive and the infrastructure
9 problems. And I think we've generally tended not to pay
10 much attention to some of those locales.

11 Chairperson Hyde: Arturo and Stephanie?

12 Mr. Gonzales: You know, I'm sympathetic to the
13 idea of getting out to see some of the projects, but I've
14 been on Council's where we're tried to do that and the
15 reality is it's a lot of money, it takes a lot of time, I
16 like Flo's idea, you know, here is where the action is
17 right now. We've got the staff here, we have the 10
18 initiatives going on, here, and if we want to see a project
19 of exemplification that would make sense to us, well, bring
20 that project over here so we can see it. you know, that's
21 another idea is just bring -- bring that in.

22 I -- I mean, you know, you talk about some people

1 back home all of the way from -- I mean, I'm being a little
2 selfish, here, all the way from Oregon, all the way, you
3 know, it's hard. I would say, let's go West, but, you
4 know, Pam has said we're not going to do that, so I'm
5 saying, "Let's not go anywhere, let's stay here."

6 [Laughter.]

7 Mr. Gonzales: But the other thought I had on the
8 meetings was, it might be helpful to have the advisory
9 meetings when you're bringing in, like, for example, the 10
10 States that are going to work on employment to somehow tie
11 the National Advisory Committee with that, after or before,
12 to see what those groups are talking about, to get a flavor
13 for what's really being planned with one of the ten
14 initiatives. Or, for example, when Dr. Clark had the
15 meeting with, in April, with the providers for manpower
16 development or something like that, to tie the national
17 meeting somehow, either before or after with that, to get a
18 sense of the flavor of what they're talking about. That
19 might be a way to get a flavor of the country, I don't
20 know.

21 Dr. LeMelle: Well, to follow Arturo, my light
22 was on before his light was, but that's okay.

1 Mr. Gonzales: My [indiscernible], I'm sorry.

2 Dr. LeMelle: There's a little competition, here.

3 [Laughter.]

4 Dr. LeMelle: But, you know, this is a technical
5 question, I mean, can we bring people here? Because
6 certainly, you know, I actually know the folks that set up
7 that program, and I don't think it would be a problem for
8 me to ask them to come to one of our meetings to present, I
9 mean, it's a fabulous program. But, you know, we don't
10 have to go to New York for that. We could, if we're -- and
11 I don't know, technically, are we allowed to bring people,
12 special guests or presenters to these meetings?

13 Chairperson Hyde: I think we can, to a point.
14 Obviously, there's a different between hearing from
15 somebody and actually seeing the program on the ground.

16 Dr. LeMelle: Right.

17 Chairperson Hyde: There's also, I just -- I'm
18 going to keep pushing, and it's not to say any program we
19 picked, you could find some way to connect it to one of
20 these 10 initiatives.

21 Dr. LeMelle: Right.

22 Chairperson Hyde: But, to the extent that that's

1 what we're trying to focus on, and you're trying to advise
2 us about our focus, I would want to make sure that whatever
3 we picked -- if we were going to spend time doing it,
4 because it takes a half a day to go see a program --

5 Dr. LeMelle: Right.

6 Chairperson Hyde: -- by the time we cart each
7 other around and all that kind of stuff. So, I don't have
8 a bit or a problem doing that, I think it would be a great
9 thing to do. The question is, does it add to your ability
10 to advise us in where we're going on one of these issues.

11 And with regard to -- we have to, people have to
12 travel, no matter what, so that's doable. Even if all of
13 our staff can't travel, we can have them on the phone when
14 it's necessary to do that.

15 Dr. LeMelle: But, I guess my thought is, I mean,
16 like, something like the Children's Zone, I' sure they
17 could have them send us materials before the meeting so
18 that we could be somewhat versed in what they're going to
19 present. We could even ask them -- send them questions,
20 specifically, or outlines of what we want -- the
21 information we want, and then when they come in, it's a lot
22 more targeted presentation. Because, frankly, going to

1 site visits, it's great to actually see stuff, but I don't
2 know that you really get a lot of the concrete logistics
3 and information that you can get sitting around a table
4 with your note pad right there and being able to ask
5 targeted questions.

6 So, I think if we were going to go that route,
7 thinking -- you know, the previous meeting, what types of
8 information would we want, who would we want to see,
9 sending that out to everyone before the next meeting,
10 giving us a chance to look at it, and maybe coming up with
11 specific questions that we want them to present, might be a
12 way to be more efficient.

13 Chairperson Hyde: All right, I think I saw
14 Cynthia's hand up and then Marvin.

15 Ms. Wainscott: Yes. It's always a hard
16 discussion when we talk about this, because everybody wants
17 you to come where they are. And you'll do a good job of
18 making the right decision. I can actually argue for
19 staying here next time to get a really good staff report.

20 Having been on two, I call them "field trips"
21 where we went away, it's hard to describe what I got out of
22 both of those. They were different from each one, but you

1 understand the heart and soul of what's going on, you have
2 a different perspective, I don't think you can bring that
3 in. So, I hope we will continue to do that to some degree
4 sometimes.

5 Answering your specific question, if you come to
6 Atlanta, you'll get Southern hospitality, first. But I
7 think one of the main things we could show you that would
8 be important would be what I believe is the primary
9 opportunity before us for workforce development, and that
10 is peers. The peer support manual was written, we figured
11 out in Georgia -- not me, Larry Frank, Sarah Jenkins
12 Tucker, those people figured out how to certify peers.
13 They've got that, and they're doing it. And it opens your
14 eyes when you watch it. We could go to the peer support
15 and wellness center, we could go to Double Trouble, we
16 could see things that would really demonstrate and are
17 demonstrating outcomes that are cheaper and often better
18 than "traditional" services.

19 We have CDC interagency collaboration, we can't
20 do it without it. We've had Larke down there for what, 6
21 months, we've made a big investment in that connection, we
22 might be able to cement it, and they need help in sort of

1 advocating within the agency, and I think we could be part
2 of that.

3 The Carter Center is a perfectly wonderful, fun
4 place to go. We couldn't do all of this, obviously, but
5 they're the leader, I believe, in the world in public
6 awareness and support for mental health. We might be able
7 to snag Mrs. Carter. We have a Mental Health Planning and
8 Advisory Council that is chaired by a substance abuse
9 advocate. I don't think there's another one in the country
10 like that. That's because we've got a really coordinated
11 advocacy group, there.

12 And probably the one that, for me, is -- would be
13 most fun, I'm going to let Judy tell you about, because we
14 both thought of the same person, but as usual, Judy's one
15 step ahead of me, and she's already had this guy come.

16 Ms. Cushing: We had the opportunity to hear from
17 -- at a large event in Portland, General Mark Graham, and
18 his wife, Carol. General -- Major General Graham is now at
19 Fort --

20 Ms. Wainscott: Fort Benning.

21 Ms. Cushing: Fort Benning, in Georgia. He was
22 one of the commanders at Fort Carson. Some of you may have

1 read about them in the Wall Street Journal or have seen
2 them on Dateline. They had a tragedy in their -- two
3 tragedies in their family, they lost a son who was going to
4 be an Army doctor, to suicide, and about a month later, his
5 brother was deployed to Iraq and was killed, within 8
6 months. So, within 8 months' time, they lost two sons.
7 And General Graham decided to come out about suicide, in
8 other words, we can't push this under the rug anymore. And
9 his -- the sharing of their story and the manner in which
10 he does it is so powerful that people are riveted to their
11 seats, and they finally begin to understand about mental
12 health, depression, suicide, and that it -- all that that
13 means. And it certainly changed the thinking of a lot of
14 people in our community, and it was a powerful, powerful
15 time.

16 Ms. Wainscott: And we might be able to get him
17 to come, and if not we could probably get his wife, and/or
18 people who are working with them, and they are in a
19 position to make things happen in some of the ways we want
20 them to.

21 So, those are things we could offer, but I trust
22 you to figure out what's the right thing to do.

1 Chairperson Hyde: Okay. I know you also have a
2 -- Atlanta also has some substance abuse and TANF-related
3 programs that are pretty unique.

4 Ms. Wainscott: And we have a new integration --
5 integrated program in Fulton County, which is the poorest
6 county in the metropolitan area, they've just, two days ago
7 opened their public mental health clinic that is fully
8 integrated.

9 Chairperson Hyde: All right. Well, we,
10 unfortunately, have to move this conversation, as well. By
11 Friday, you have the plane ride home, and that's all, to
12 think about this. If you have any other thoughts about
13 where, and the focus of the next meeting, for example, if
14 you had -- and that's where you were going, I think -- if
15 you have some specific things around these 10 initiatives
16 that you think a particular site or a particular place
17 would help with, please send those to Toian, we'll take a
18 look at them. I'll talk frankly to our staff and see what
19 it means about all of our lives and stuff, we'll get a date
20 and we'll get that out to you.

21 So, we will have to make an executive decision
22 and get on with this one, but thank you for the input.

1 Ms. Wainscott: Yeah, I would ask you to think
2 about having it in September to get us back on our regular
3 schedule. In other words, we waited for you.

4 Chairperson Hyde: Yeah, and I waited for the
5 White House to say it was okay to bring these other people
6 in, so yeah, we did. We did wait a little bit, that's
7 true.

8 Ms. Wainscott: There's some advantage to sort of
9 getting a quick update and then sort of being back on
10 schedule, if you can pull it off.

11 Chairperson Hyde: Okay, all right. Got it,
12 yeah.

13 All right, thank you. That's -- everything,
14 everything we've done with you all has been a rich and full
15 discussion. It's great. I love this group.

16 All right, we're going to go to public input,
17 we've got three people that we are aware of, all on the
18 line, right? Two on the line -- two here and one on the
19 line?

20 So, the two here, the first one is John Rosiak,
21 from the National Center for Mental Health Promotion and
22 Youth Violence Prevention.

1 Mr. Rosiak: Good afternoon, my name is John
2 Rosiak, I work for the education and development center,
3 and we actually run the National Center for Mental Health
4 Promotion and Youth Violence Prevention, which is very
5 pleased to be the technical assistance provider for CMHS,
6 for the Safe Schools/Health Schools initiative.

7 The focus of my comments really is on
8 integration, it's something that we talked about quite a
9 bit yesterday, that meaning integration or collaboration of
10 partners in the community from multiple disciplines that
11 come together to address the behavioral outcomes that we've
12 all been talking about the last day and a half.

13 The Safe Schools/Healthy Students initiative, for
14 example, really is a model of integration in that about a
15 dozen years ago, actually prior to Columbine, several
16 Federal agencies came together, Health and Human Services,
17 Department of Justice, Department of Education, realizing
18 that to address the multiple, complex problems in our
19 community we needed to really look at integration and
20 collaborative solutions. In fact, when the Federal
21 government puts out the RFA for Safe Schools/Healthy
22 Students proposals, they demand that a collaboration,

1 Memorandum of Understanding be part of that -- that all of
2 the partners are innovating to come to the table there.

3 SAMHSA's mention, I think, our message, is great.
4 Prevention works. I think one of the things that we
5 clearly learned is that integration works, integration of
6 systems, collaboration works. Collaboration, intervention
7 really are key strategies for prevention, and I applaud the
8 conversation about that, particularly yesterday was a lot
9 of focus on integration.

10 And while innovation and collaboration can be
11 very challenging, they are really the key to creating
12 systems change. Systems change that really moves the
13 behavioral outcomes. That's what, really, the initiatives
14 that the National Center is about and I think hold a lot of
15 promise for the future, for sustainability, too.

16 And lastly, on the basis of the work of the
17 National center for Mental Health Promotion and Youth
18 Violence Prevention, the message to the National Advisory
19 Council is that integration of multiple partners, multiple
20 systems, really is the way to go to create the systems
21 change that we want. And it's so important to support
22 efforts which support integration. And there are four ways

1 I'm going to leave you with.

2 One is, to look at combined funding, for example,
3 from different Federal agencies to support initiatives, to
4 look at designing initiatives that require integration,
5 local collaborations, as has been talked about, of
6 community partners. Three, to develop tools, tools that
7 help community with very specific integration tasks, for
8 example, yesterday we talked about information sharing
9 quite a bit. I can tell you, locally, information sharing
10 is a major issue as Ms. Hyde mentioned, a lot of
11 misperceptions about that. The tools people, locally,
12 really need.

13 And lastly, to support communities with technical
14 assistance, which is so important in making integration
15 work best.

16 Thank you.

17 Chairperson Hyde: Great. Thank you very much.
18 I assume you'll give us your written comments, or I noticed
19 you had some notes there, so great, thanks a lot.

20 Donovan Kuehm? If I'm pronouncing that right?
21 From the National Association for Addiction Professions?

22 Mr. Kuehm: Hi, everyone. My name is, actually,

1 Donovan Kuehm, that's okay, I've got a really tough name.
2 And for the transcriber, it's D-O-N-O-V-A-N K-U-E-H-M, just
3 to make your life easier.

4 Just, first of all, I've been watching the
5 deliberations, I wasn't able to make it out yesterday but I
6 did watch the Web cast yesterday, and you all are very
7 telegenic, I just wanted to reassure you.

8 [Laughter.]

9 Mr. Kuehm: I'm here, actually, from --
10 representing NADAC, the Association for Addiction
11 Professionals. And we have almost 10,000 members across
12 the United States. I'm here to express support for a
13 couple of initiatives that are going on right now, one is
14 the Health IT Initiative, which our Association is very
15 supportive of. Unfortunately, in its current form, it
16 would exclude most of our members from participating. So,
17 I know this regulatory fix that's before Congress that
18 Representative Kennedy has set forward, so we're very
19 hopeful that that's going to be implemented.

20 Secondly was the issue, I think, that Dr. Clark
21 brought up yesterday of the workforce, the addiction
22 workforce, and we're very focused on awards, recruitment

1 and retention, because we know that the workforce is
2 getting older, and that we need new people to come in and
3 actually take the places of people who are going to be
4 leaving the profession. So, that's something.

5 And one thing that we've actually worked with is
6 we've collaborated with the addiction technology transfer
7 centers on recruitment packages. Including, I'm not sure
8 if anyone's seen it, but there's a program called Imagine
9 Who You Can Save, which is a short, 3-minute video. But it
10 talks about, it has people who work in the addiction
11 profession, and just talking about who they've gotten
12 involved, and we're hoping that's going to be a good
13 recruitment model. So, that was a nice collaboration.

14 And the only other thing I'd like to put out
15 there, is we do have 10,000 members across the country, and
16 we definitely -- we have members in every State, and we
17 would like to be there to support you and to partner with
18 you.

19 So, please do think of NADAC, the Association for
20 Addiction Professionals, and how we can sort of be there to
21 help you as these initiatives move forward, thanks.

22 Chairperson Hyde: Great, thank you very much.

1 Okay, that's the last person I'm aware of with public
2 input, so if anybody needs any -- say any last thing, you
3 have 2 seconds -- gone.

4 Thank you.

5 Adjourn? Motion to adjourn, I guess we need.

6 [Applause.]

7 Chairperson Hyde: So moved from Don, seconded
8 from Marvin, and we are adjourned. Thank you very much.

9 [Whereupon at 2:34 p.m., the Council was
10 adjourned.]

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