

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

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

47th Meeting

SAMHSA National Advisory Council

May 11, 2010

Rockville, Maryland

1 [On the record, 9:04 a.m.]

2 Chairperson Hyde: Okay, good morning,
3 everyone. We're going to get started. Welcome to the
4 SAMHSA National Advisory Council meeting. I'm going
5 to turn this -- I'm Pam Hyde, the Administrator of
6 SAMHSA. I'm going to ask Toian to explain a little
7 bit about the setup and the electronics and the
8 logistics for today, and then we'll get started.

9 Ms. Vaughn: I'm Toian Vaughn, the
10 designated Federal Official for the SAMHSA National
11 Advisory Council. Before calling the meeting to
12 order, I would like to point out to the Council
13 members and to staff and members of the public
14 attending in person that this session will be taped
15 and video streamed. This is an opportunity for us to
16 provide maximum access to the public, at large, to
17 attend the SAMHSA Council meeting and, hopefully,
18 future Council meetings. As you can see, there are
19 three cameras placed around the room. We are assured
20 they will be as unobtrusive as possible.

21 Members of the public who are joining us by
22 way of Web stream, and have pre-registered to deliver

1 comments to the Council and SAMHSA, will have an
2 opportunity to do so at approximately 5:00 p.m. EST.
3 A flyer will appear on your screens to alert you of
4 the contact number, and instructions for dialing.
5 Please provide the operator with your name, your
6 affiliation, and follow the instructions that he or
7 she will provide you; that's very important.

8 In addition, for the SAMHSA staff and the
9 Council members, you need to use your mic in order to
10 ensure that the public is able to hear you. And in
11 addition, when you finish with your presentation, you
12 should turn off your mic, because as -- when you get
13 two or three mics on, you start getting feedback. So,
14 it's very important that, as you finish with your
15 remarks that you turn your mic off.

16 I will now call the 47th Meeting of the
17 SAMHSA National Advisory Council to order.

18 Ms. Hyde, you have a quorum, and I'm handing
19 the meeting over to you.

20 Chairperson Hyde: Thank you. Thank you,
21 Toian.

22 This is -- this technology's quite

1 interesting, isn't it? So, we've got, as I understand
2 it, about 170 people, or so, that were registered to
3 listen and participate with us by web, so we're
4 serious about people being able to listen in, and that
5 means you all should know that there's a whole group
6 beyond who you see here in the room that are able to
7 experience this with us today.

8 This is my first NAC, or National Advisory
9 Council Meeting as Administrator, so I'm really
10 excited about it. I do want to thank Toian and all of
11 the staff that have been working on getting this
12 ready, but frankly, just getting me briefed and
13 prepped, which is no small feat. So, thanks a lot,
14 for all of you.

15 I do want to tell you that we really --
16 well, I also want to tell you that Terry Cross is
17 joined by phone, is that correct, Toian? Is he?

18 Ms. Vaughn: Not yet.

19 Chairperson Hyde: He has not called in,
20 yet, but he's going to. So, Terry Cross, who is also
21 a member of the Council will be on by phone,
22 eventually.

1 So, we have some new Council members, so let
2 me just point them out, although everybody's going to
3 get a chance in a minute to say hello and tell people
4 who you are.

5 But, Kate Aurelius from Phoenix; Arturo
6 Gonzales from New Mexico; Stephanie LeMelle from New
7 York; and Don Rosen from Oregon.

8 Now, I know this means that we have two
9 members from Oregon, I'm not sure exactly how that
10 happened --

11 [Laughter.]

12 Chairperson Hyde: Three. Oh, Terry, oh my
13 goodness, all right, we have an Oregon contingent this
14 -- today. So, it's a good thing.

15 Also want to just take a minute and note
16 that Faye Gary's term has ended. Faye was with us
17 earlier, she's here in the audience? Faye, you want
18 to come up so we can kind of see you? It's dark back
19 there, so it's hard for us to see you.

20 I want to express my sincere appreciation
21 for Faye Gary's service on the SAMHSA Council from --

22 [Applause.]

1 Chairperson Hyde: December -- she's been
2 with us from December 2005 through November of 2009.

3 Her strong commitment, knowledge, and
4 leadership in improving the quality and availability
5 of treatment and prevention services for substance use
6 and mental disorders contributed to the success of
7 this Council and of SAMHSA. So, you and the Council
8 have helped SAMHSA achieve its distinctive mission to
9 reduce the impact of substance abuse and mental
10 illness on American communities.

11 So, I'm very pleased to present you this
12 plaque, acknowledging SAMHSA's appreciation for your
13 work on the Council.

14 Ms. Gary: Thank you so much.

15 [Applause.]

16 Ms. Gary: I just would like to thank
17 everyone who supported me, our different philosophical
18 points of views were well-discussed and well-accepted.
19 I have found new and enduring friends, and I leave the
20 Council with the sense of assurance that people with
21 mental illnesses and substance abuse burdens will be
22 cared for, because of your commitment, your knowledge,

1 and your leadership. And for that, I'm most grateful.

2 Thank you so much.

3 [Applause.]

4 Chairperson Hyde: So, thanks for your
5 support and advice. And those of you who are new on
6 the Council will have big shoes to follow, here, as
7 some folks go off.

8 I just want to, also, acknowledge, we're
9 going to hear from Tom later, but Tom Kirk, who I
10 understand has already been acknowledged at another
11 meeting, but he is also going off the Council. Tom's
12 an old friend and colleague and I'm really pleased to
13 see him here, and pleased to see that he's been a part
14 of this effort, as well.

15 So, Tom, back there in the back, thank you
16 for being here today. And Tom has a role, tomorrow,
17 so he'll be listening and has a role tomorrow for us.

18 All right, before we go any further,
19 actually, let me just thank a couple of other people
20 and then we'll go around and do introductions. And, I
21 apologize, there's something on the floor, here, that
22 makes it hard to get around. Also, want to just take

1 an opportunity to thank Rick Broderick, he's not here
2 this week, he's actually on a much-deserved vacation.

3 Rick was the interim Administrator several
4 times, or at least a couple of times. He's done a
5 terrific job at keeping SAMHSA going, and frankly, at
6 supporting me as I came in as Administrator. He has
7 resumed his role as the Deputy Administrator, and is
8 continuing to do terrific things, and work for us.

9 So, on the record, I want to acknowledge
10 Rick for his wonderful leadership and hard work. So,
11 thank you, Rick. I have to make sure he listens to
12 this so he can hear that.

13 I also want to thank the Center Directors,
14 many of whom are here -- they're going to be here
15 throughout today and tomorrow off and on, depending on
16 what else -- there's a lot of other things going on
17 today.

18 So, Fran Harding from the Center for
19 Substance Abuse Prevention is over here; Westley
20 Clark, Center for Substance Abuse Treatment; and, Dr.
21 Marsh for Kathryn Power is here for the Center for
22 Mental Health Services; Pete Delany is here from the

1 Office of Applied Studies, soon to be a Center of
2 Something, we're still figuring out what that name is,
3 and then Kana Enamoto -- where's Kana? Way back
4 there, Kana's always quietly in the background, but
5 being very effective at leading policy and program
6 issues, and then Daryl Kade, to my left, here, who's -
7 - I guess your new title is CFO? Or is that your
8 current title?

9 Ms. Kade: Current title.

10 Chairperson Hyde: Current title, as well.

11 Larke Huang is one of our Special Assistants
12 -- where is -- special -- where is she? She's not
13 here, yet, but she'll be around later, because she
14 leads on a couple of our initiatives, and Mark Weber
15 is back in the audience, there, Office of
16 Communications Director, and also a lead on one of our
17 initiatives.

18 So, there may be other SAMHSA staff, let me
19 take a minute to introduce you to Ben Belton, he is a
20 new staff person in our office, supporting me on many
21 things. He's all of 3 weeks now, been? All right,
22 good.

1 John O'Brien, you're going to hear from in a
2 little bit. He's the new Special Advisor on Health
3 Reform, Health Financing issues, and so you'll meet
4 him, as well. And, again, there may be other staff
5 around, but we'll introduce those to you as they come
6 and go.

7 All right. Well, let's stop and take a
8 minute to let each of you introduce yourself, and then
9 we'll talk a little bit about the paper that's in
10 front of you, and then I'll make a few remarks and
11 we'll get going.

12 So, what I'd like to do is have you all say,
13 obviously, your name, where you're from, and just a
14 minute or two about the perspective you bring to the
15 Council. Because we did try, very hard, with both the
16 existing members and then the new members we brought
17 in, to make sure that we have a variety of
18 perspectives on the Council. So, make sure folks know
19 what that is. So, Wang, you want to start?

20 Dr. Wang: Good morning, I'm Ed Wang, from
21 the Massachusetts Department of Mental Health. I just
22 wanted to say that my passion and commitment is

1 towards the reduction and elimination of disparities
2 through evidence-based, culturally adapted service
3 promising models. Thank you.

4 Chairperson Hyde: Great, thank you.

5 Ms. Stein: I'm Flo Stein from North
6 Carolina, I'm with the Division of Mental Health,
7 Developmental Disabilities, and Substance Abuse
8 Services. It's been an integrated agency for about 15
9 years, so I hope that gives us some tools to work
10 with, going forward.

11 And what I'm hoping for is to help our
12 consumers and our providers and the leaders in our
13 State, understand the transformation that we're going
14 to go through and hope that improves access.

15 Dr. Rosen: I'm Don Rosen, from Portland,
16 Oregon. What drew me to this Council was the interest
17 in healthcare reform and workforce development, and
18 the application of public health services.

19 Ms. Cushing: Good morning. My name is Judy
20 Cushing, and I am a founder of a non-profit in Oregon
21 called the Oregon Partnership. We provide prevention,
22 education and crisis intervention services to

1 Oregonians, and those beyond, in the Northwest.

2 I am very proud to serve on the Council and
3 my passion is bridging prevention and mental health
4 services and treatment services across the continuum
5 to do away with the silos that we've lived with for so
6 long, and now we have this wonderful opportunity with
7 mental health prevention and treatment, to come
8 together and look at things holistically and serve the
9 people who are on the ground, our consumers, with
10 stakeholders from all sectors. I think we don't do a
11 good enough job of involving both the business sector,
12 the private sector, the public sector and the
13 citizenry.

14 Mr. Braunstein: Good morning, I'm George
15 Braunstein, the Executive Director of the
16 Fairfax/Falls Church Community Services Board in
17 Virginia. And my primary interest in being here --
18 I'm also a Chair of Public Policy for the State
19 Community Service Board System in Virginia, and
20 involved in policy -- how it translates into the
21 actual front lines of service delivery. And so, I'm
22 quite interested in seeing -- especially now, with the

1 Federal Government moving on healthcare reform -- to
2 see how that translates into those front lines of
3 service delivery.

4 Ms. Wainscott: I'm Cynthia Wainscott from a
5 little town called Emerson just north of Atlanta. I
6 am the daughter, mother, and grandmother of people who
7 have lived, successfully, with mental illnesses. And
8 I believe passionately that behavioral health is
9 essential to mental health, that prevention works,
10 that treatment is effective, and that people recover.
11 I am delighted to see that on the front page, what a
12 great summation.

13 I think two of our greatest opportunities,
14 and ones you may hear me talk most about are directly
15 tied to the first two of those -- behavioral health is
16 essential to health. The integration movement is ripe
17 in America, it is not yet blooming, but it is the way
18 to get people treated earlier, and prevention works.
19 There is science to prove that, we have to be
20 aggressive, I believe, about saying the truth and
21 insisting that actions occur on it. And, of course,
22 treatment is effective and people recover. I've seen

1 that happen in my own immediate family. It's been
2 wonderful to watch, and it is painful that most people
3 who need treatment don't ever get it. And you'll hear
4 me complain about that, on occasion.

5 Dr. LeMelle: Good morning, I'm Stephanie
6 LeMelle from New York. I self-identify as a public
7 psychiatrist. I worked with the MacArthur Foundation
8 on the Network for Mandated Community Treatment, so I
9 have a real interest in the overlap between the
10 criminal justice system, and mental illness and
11 substance abuse areas.

12 I also work with an organization in New York
13 that's called Pathways to Housing, which is a housing-
14 first model, that really looks at the consumer and
15 consumers' rights, and housing as a right, and as a
16 first step towards recovery. And, I guess, so the two
17 areas that I'm primarily interested in are the overlap
18 with the criminal justice system and the overlap with
19 housing and homelessness.

20 Mr. Alexander: Hi, I'm Marvin Alexander, I
21 am a clinician at a community mental health center in
22 Jonesboro, Arkansas.

1 What brings me to this Board is just my
2 perspective as a young person. And I usually say, the
3 youngest member of the Board. But, my passion is
4 really making sure that children, youth, and families
5 have the services that they need. As a child, I was a
6 consumer of services. And now I'm a provider of
7 services. So, really, it's a message of hope, and
8 being able to help society see that young people,
9 children -- there are issues that -- they transcend.
10 And to get services -- and really, to focus some
11 attention on those issues that affect children, youth,
12 and families, particularly minority youth, and youth
13 who, really, that won't have access if other people
14 aren't being their voice.

15 So, thank you.

16 Mr. Gonzales: Good morning, buenos dias,
17 Senors. My name is Arturo Gonzales, I'm from Santa
18 Fe, New Mexico. I'm the Executive Director of Sangre
19 de Cristo Community Health Partnership. In days past,
20 when Secretary Hyde was Secretary of Human Services in
21 New Mexico, Sangre de Cristo was responsible for the
22 implementation and monitoring of the Screening, Brief

1 Intervention, Referral, and Treatment Program known as
2 SBIRT. I believe I bring to the Council, hopefully, a
3 passion for delivery of integrated behavioral health
4 and medical care services in rural areas using
5 technology to do that, such as Telehealth, and
6 evidence-based practices that are inclusive of
7 minority groups, such as Hispanics, Native Americans,
8 et cetera. And it's a pleasure to be with you.

9 Ms. Aurelius: Good morning, my name is Kate
10 Aurelius, I'm Deputy Director for the Arizona
11 Healthcare Cost Containment System, which is our
12 Medicaid program in Arizona. And I'm really
13 interested in integration of care that results in
14 high-quality performing systems that can be delivered
15 at a reasonable cost and measuring outcomes so that
16 we're actually getting what we're purchasing.

17 Chairperson Hyde: Thanks. I'm going to let
18 the -- thanks to all of you.

19 Oh, Terry Cross, I think, has now joined us
20 by phone. Terry, do you want to introduce yourself?
21 There's a little delay, hang on. Terry, do you want
22 to introduce yourself?

1 Mr. Cross: Ah, yes. Great.

2 This is Terry Cross, I'm the Executive
3 Director of the National Indian Child Welfare
4 Association and a member of Seneca Nation of Indians.
5 And our passion is the wellbeing of American Indians,
6 children and families. We're working across the
7 country with tribal governments and urban Indian
8 programs to develop those services for children and
9 families, particularly child welfare and children's
10 mental health. And my passion is cultural competence,
11 and making sure that the mental health field is
12 responsive to the needs of Indian children and
13 families and other American Indians, as well. Thank
14 you.

15 Chairperson Hyde: Great, thanks.

16 There is one other person who will be
17 joining us tomorrow, Hortensia Amaro. I have not met
18 her, yet, so I'm looking forward to that. So, she'll
19 be with us tomorrow.

20 And then we have two ex officio members, the
21 Secretary, Kathleen Sebelius, who is doing many things
22 today, one of which is releasing the -- helping to

1 release the President's National Drug Control Policy,
2 so we'll be talking about that a little bit more
3 later.

4 And then, Lawrence Lehmann, who is from the
5 VA, from the Veterans Administration, is an ex officio
6 and, do we know if he's going to join us, or not?
7 He's going to also join us tomorrow. So, a couple of
8 other folks.

9 And otherwise, we have great representation
10 today, so that's terrific.

11 I do want to let the staff sitting around
12 the table introduce themselves, because they all have
13 roles, here, and presentations today. So, just
14 briefly, if you want to do that. I did mention them,
15 but let's let them talk about themselves, here, for a
16 second.

17 Ms. Harding: Good morning, I'm Fran
18 Harding, the Director of the Center of Substance Abuse
19 Prevention, and also the lead on the initiative one,
20 one of our ten initiatives, which is prevention of
21 substance abuse and mental illness.

22 Dr. Clark: I'm Westley Clark, I'm the

1 Director of the Center for Substance Abuse Treatment
2 and I'm the initiative lead on behavioral health IT
3 and workforce development.

4 Dr. Delany: I'm Pete Delany, I'm the
5 Director of the Office of Applied Studies and the lead
6 on data outcomes and quality and ably assisted by Rick
7 Broderick and Daryl Kade.

8 Ms. Kade: Good morning, my name is Daryl
9 Kade, I'm the Director of the Office of Policy,
10 Planning, and Budget and the CFO, soon to be morphed
11 into another office.

12 Chairperson Hyde: Soon to be.

13 All right, thank you. And you'll hear from
14 John O'Brien, and Mark. Do you guys want to introduce
15 yourselves real quick? You'll have to run up here to
16 a microphone.

17 Mr. O'Brien: Good morning, I'm John
18 O'Brien. I'm the Senior Advisor on Healthcare
19 Financing.

20 Mr. Weber: Again, good morning, the
21 Director of the Office of Communications. I look
22 forward to talking with you later today.

1 Chairperson Hyde: So, let me just talk a
2 bit about the agenda, today.

3 Ben, I didn't let you introduce yourself.

4 Mr. Belton: Good morning, my name is Ben
5 Belton. I'm Pamela Hyde's Special Assistant -- well,
6 confidential assistant.

7 Chairperson Hyde: We're struggling with
8 some titles, here, can you tell? John's got his down,
9 finally. I don't, yet. I still struggle with that
10 just a little bit.

11 I do want to tell you that we have a very
12 exciting guest today at 5:30 for those of you who are
13 willing and able to stay around. Gil Kerlikowske, who
14 is the White House, often-called, National Drug Czar,
15 will be here to tell us about the roll-out of the
16 White House -- the National Drug Control Strategy. It
17 is being rolled out today with the press and with
18 stakeholders, so Fran and I will actually leave about
19 2:00 and go do a half an hour with press on that
20 issue. You're going to be hearing about our
21 communications and public support strategy during that
22 time, we figured Mark could do that without us for

1 just a minute or two, while we go do press and
2 communications and public support. And then at -- I
3 believe it's at 4:00, there's a stakeholder call for
4 that strategy roll-out, and then Gil is actually going
5 to come out here to do a personal presentation to you
6 all about that.

7 So, it's going to be kind of a long day, but
8 I think it'll be kind of exciting to see where that's
9 going. We -- our staff, especially Fran and Wes, have
10 been very engaged in that strategy development and we
11 have lots of staff who have been working on that --
12 and will be working on the implementation of the
13 strategy. I think when you see it this afternoon,
14 you'll be pleased it does, definitely, represent more
15 than interdiction, definitely represents a lot of
16 demand reduction at this point, and that's their words
17 for services and treatment and prevention.

18 So, you'll be hearing more about that today.
19 So, we're really excited that he's coming. He's been
20 a great partner for us in these efforts, as has the
21 Deputy over there, Tom McClelland, who I think some of
22 you know quite well.

1 All right, let me just say a word or two
2 about myself, and about SAMHSA and about what we're
3 trying to do here. I just finished my 5th week, or
4 I'm into the 6th week -- month, month, here, but who's
5 counting. It's hard to believe it's been 5 months and
6 yet hard to believe that it hasn't been a long, long
7 time and I suspect the staff sort of feel the same
8 way. We've been doing a lot, and I give them a lot of
9 credit for both being very creative, open, willing
10 partners in sort of trying to move the Nation's
11 behavioral health issues forward.

12 I might say, before I go any further, we've
13 had a lot of discussion, here, about use of terms.
14 And one of the terms that I use, frequently, because
15 frankly it was a term we used in New Mexico is
16 behavioral health. It's not particularly a term that
17 I like all that much. There are lots of reasons why
18 people are not particularly comfortable with the word
19 behavioral health, but I sometimes struggle with using
20 words that encompass the full range of promotion,
21 prevention, substance abuse, substance use disorders,
22 mental health, mental illness and everything in

1 between.

2 So, it gets very difficult to figure out
3 exactly what collective word you can use without
4 having a sentence a mile long.

5 So, for those of you who are not
6 particularly happy about that word, just know I'm not
7 particularly happy about it, either. We are,
8 actually, struggling a little bit on what words to use
9 that will be the right way to talk about this
10 collectively.

11 I feel very strongly that we not separate
12 out substance abuse from mental health and vice versa,
13 or substance use disorders from other kinds of mental
14 illness disorders, because we're trying very hard to
15 use the best we have from both the addictions field
16 and the mental health/mental illness/psychiatric
17 field, and we're also trying to recognize the
18 incredible amount of co-occurring disorders that there
19 are in our field, collectively, all together.

20 So, at any rate, to the extent that I use
21 the term behavioral health, I hope people won't be
22 offended and will know why, I really use it as an all-

1 inclusive term for all of those things we just
2 discussed. What I don't mean by that term, and we've
3 been asked this, is I don't particularly mean the
4 issue around behaviors associated with conditions like
5 diabetes or like other physical health conditions
6 where a person's behavior -- with the treatment or
7 with the approach, sort of, behavioral medicine, I
8 think, sometimes people call it -- that's not what I'm
9 using the term to mean.

10 So, hopefully that's helpful. And if others
11 use that term or choose to use other terms, whatever
12 you prefer is fine with us at the moment. I think
13 you're going to see something come out soon in our
14 newsletter called, "What's In A Term?" because we've
15 had so much discussion about terms and not any of them
16 are sufficient for all stakeholders and all purposes.

17 I think most of you know that I've been in
18 and around the behavioral health field and healthcare
19 and human services for all of my career, mostly in the
20 public sector with a few little stints here and there
21 in the private sector, non-profit world or in the
22 consulting world.

1 I am very pleased to be at SAMHSA. It feels
2 like the right time and the right place for me as a
3 person, as well as it's a great time to be with the
4 wonderful staff here at SAMHSA and the incredible
5 opportunities that are going on in Washington right
6 now.

7 It is pretty intense, both in terms of the
8 work and the learning, and the additional effort
9 that's going on because of health reform
10 implementation which you're going to hear some about
11 this morning.

12 But what we've tried to do in that period of
13 time is be clear about, for the next little while, how
14 we frame our mission, which we're talking about it as
15 trying to reduce the impact of mental illness and
16 substance abuse on America's communities. Hopefully
17 that has lots of implications about what we're trying
18 to do in that work.

19 We're also working to focus on people of all
20 ages with, or at risk of, mental or substance use
21 disorders, that they all should have the opportunity
22 to have a fulfilling life that includes a job, a home,

1 and meaningful personal relationships with friends and
2 family. That may sound familiar. That's sort of the
3 "life in community for everyone" that SAMHSA's had as
4 a phrase for a long time. It does seem to be very
5 consistent with where we're going these days, so we
6 are embracing that.

7 SAMHSA, in collaboration with a lot of other
8 Federal agencies, States, tribes, local organizations,
9 and individuals, including consumers in the recovery
10 community, have been working very hard on some key
11 messages. And those four key messages are -- you're
12 going to see a number of times today. They're
13 actually up there on the screen: that behavioral
14 health is essential to health; that prevention works,
15 that treatment is effective and that people recover --

16 [Phone noise interference.]

17 Chairperson Hyde: We have someone calling
18 in.

19 At any rate, you will see these messages in
20 a variety of places. One is on the front cover, which
21 is what that is -- that is, right after your agenda,
22 you have your agenda, and then you have a piece of

1 paper --

2 [Phone noise interference.]

3 Chairperson Hyde: Can we get that turned
4 off somehow?

5 Okay, maybe that did it.

6 So, that handout, we're going to be
7 referring to, again, that Power Point slide we're
8 going to be referring to throughout the day. It has
9 information in it about our initiatives and about what
10 we're trying to accomplish with it.

11 There's also, in your handout, somewhere,
12 there's a piece of paper that looks like this. It's
13 called -- it starts with the word "mission" at the
14 top, it's got SAMHSA at the top and then the word
15 "mission." This is everything from a statement of
16 mission and the messages -- you'll see the four
17 messages there. Underneath those four messages,
18 there's some quick facts, or fast facts, that go with
19 those messages that we're trying to put forth. And
20 then starting on page two -- no, it actually goes all
21 the way over -- so the four messages and their facts
22 go all the way to page three. Starting in the middle

1 of page three of this document is SAMHSA's role, and
2 the reason that we did that is we -- I found early on,
3 in talking to people, that a lot of folks were
4 thinking of SAMHSA as primarily a grant-making
5 organization. And we do, obviously, give out grants.
6 But we do a lot more than that. We not only fund the
7 programs, but we also provide leadership and voice in
8 the country around behavioral health issues, and we do
9 that from -- and everything from providing the
10 expertise, to collaborations, to convening, et cetera.
11 We also help with policy development, commenting,
12 support, doing a lot of leadership around those issues
13 these days.

14 We're also, in addition to funding grants,
15 we're trying to build capacity in our grantees and
16 we're trying to work with emergency responses. We've
17 had a lot of disasters, crises and other things
18 between Haiti and Tennessee flooding, and you know,
19 lots of other things, and we do provide both
20 assistance, as well as grants, in those situations.

21 We're also trying to do increased work in
22 information and communications. You're going to hear

1 a little bit more about that. We clearly are the
2 place that people come for lots of information and
3 we're trying to make that easier to do and make that
4 clearer -- that like CDC and immunizations, if you
5 want to know about behavioral health, you should go to
6 SAMHSA. We're trying to make that kind of connection.

7 We also do a lot of regulation and standard
8 setting, which sometimes people don't realize, as
9 much. We'll -- we may talk about that a little bit
10 more in other contexts. And then, we do a lot of work
11 around practice improvements, so everything from
12 registering evidence-based practices, to training and
13 teaching and conferences and guidance to the field and
14 dissemination of efforts that we learn and that others
15 learn, et cetera.

16 So, that's what the SAMHSA role information
17 is about, and I wanted to kind of have you have that
18 in your head as we talk about the initiatives.

19 The ten strategic initiatives is what we're
20 going to focus on in the next two days. We have
21 identified ten areas, and as you go through them you
22 will see that not once do they say mental health, or

1 mental illness, or substance abuse or whatever except
2 for, perhaps, prevention which tries to prevent
3 everything, all of the bad stuff. Because we're
4 really trying, in all of these initiatives, to work
5 across the Agency, not just in one Center or not just
6 in one field. So, the leaders of these initiatives,
7 which are identified on your sheet, are going to be
8 presenting to you, and they will be doing just a ten
9 or fifteen-minute presentation within, anywhere from
10 30 to 45 minutes for discussion.

11 The order of these initiatives in this
12 document is, in fact, important. It's important
13 because the first three initiatives, trauma and
14 justice -- and that's trauma and justice, not trauma
15 injustice. And third, military families -- those are
16 the three top priorities that fit into the overall
17 Health and Human Services Secretary's strategic
18 planning that she's working on. That doesn't mean the
19 other things don't fit -- they absolutely do. But in
20 terms of the three main things that Secretary Sebelius
21 is looking to SAMHSA to lead on and have an impact on,
22 those top three are it.

1 The fourth one, health reform, one could
2 argue is overwhelming all of us, and that's why we're
3 going to start with it this morning. So, there's some
4 combination of what's important for you to hear first,
5 and then, just frankly, who's available when for the
6 agenda today.

7 But you're going to hear about that first
8 because it really is touching a lot of the other ones,
9 and it's sort of an overwhelming set of activities
10 right now that SAMHSA is try very hard to be at the
11 table for the entire behavioral health community and
12 field, as we go through that effort.

13 The next couple that you're going to hear
14 about are housing and jobs and the economy which,
15 again, may seem pretty big. You'll hear how our focus
16 is going in the housing arena from not just homeless
17 services but services that help people move into
18 permanent supportive housing and stay there.

19 And then jobs and the economy -- we're not
20 trying to fix the entire economy or the Dow Jones or
21 anything like that. What we're trying to recognize is
22 the issues within the economy, when an economy is

1 struggling, that increased behavioral health issues
2 arise. Health information technology and workforce
3 are two very important capacity issues in our field.
4 You'll be hearing about those and then data outcomes
5 and quality is cross-cutting in the sense that every
6 one of our programs need to pay attention to what kind
7 of data, what kind of outcomes, what kind of quality
8 are we trying to push. And then public awareness and
9 support, of course, is also cross-cutting in terms of
10 SAMHSA's capacity to help the field have -- and the
11 general public -- have information about where they
12 can go to get help, what they need to know about
13 services, et cetera.

14 So, that's kind of the ten initiatives,
15 that's what we're going to be spending our time on
16 over the next two days. That's a lot of different
17 stuff, but hopefully it will keep things lively. Lots
18 of different things to talk about, and as I heard you
19 all introduce yourself, it sounds like all of you are
20 going to get to touch on something that you care about
21 in these two days.

22 Let me just say a word about advice before I

1 sort of go back to, maybe, some talking points, here.
2 And that is, in my career I've worked with an awful
3 lot of Advisory Boards and Advisory Councils. And I
4 think they are incredibly important. And I think you
5 all are incredibly important. A lot of times, I
6 think, Advisory Councils struggle to sort of figure
7 out what's the value-added and what's the product or
8 what's the outcome of your work with us.

9 And I want to -- I just want you to know
10 that I've always thought of advice as a product, I
11 mean, I really mean that -- that your advice is the
12 product. I could talk to one of you and you might
13 tell me something, but your collective interaction and
14 discussion is a different set of advice that really
15 does have an impact on how we see our work.

16 So, we don't necessarily have to have a
17 program or a product that's on paper or something else
18 come out of this group, although if that's something
19 the group is interested in doing, that's fine. But
20 we're not trying to put more work on you, in the sense
21 of going and doing other things. What we're trying to
22 do is tell you what we're doing, and ask you to advise

1 us on that. Is it the right things? Is it, something
2 missing? Are we doing it the right way? Is there a
3 better way for us to be thinking about it? And in
4 that regard, our ten initiatives are really a work in
5 progress; they have truly been evolving over the last
6 five months. We are in the process of trying to put
7 together a paper that we will put out, very quickly,
8 into the public as a draft for everyone to react to.
9 I didn't want to put that public paper out until we
10 had met, because while we have some drafts we want
11 your advice and input and thinking before we finalize
12 that paper. And the paper will first go out, as I
13 said, as a draft for the public to respond to, and
14 then it will eventually be finalized into our
15 strategic plan.

16 We have a strategic plan right now, but we
17 are required to update it every two years. It would
18 have been updated in a few months, anyway, so we are
19 doing that now with -- around these ten initiatives.

20 So, your work with us in the next two days
21 is very critical to our process, and I hope when you
22 leave here tomorrow, you feel like you've had ample

1 opportunity to give us your thoughts and feedback, and
2 if you should feel there are other things you'd like
3 to say, you are more than welcome to email me or Toian
4 or Ben. I think it's helpful, if you would, to cc:
5 whatever you're doing to Toian so we can keep it all,
6 at least we know we've picked everything. I have to
7 admit that I have difficulty keeping up with all of
8 the emails sometimes. So, if you make sure you either
9 send it to Toian or cc: her, then we will make sure it
10 all gets captured for the record.

11 And if you want to talk with me, you're
12 welcome to try to make that happen, and I only say
13 that because it's very -- my schedule is pretty nuts,
14 but I really want to be available to you if I can.
15 But I -- again, I encourage you to use Toian and the
16 people who work with her, and Ben to try to make that
17 happen. Is this going in and out a little bit? Back
18 on? All right.

19 So, that's kind of how I think about advice
20 and advisory groups and I'm going to do my best to be
21 here with you all day today and all day tomorrow,
22 which is, I hope, some evidence of how much it is

1 important to me to hear from you, because that's a lot
2 of time out of my schedule, and it's a very important
3 time, I've been looking forward to for some time, so
4 I'm glad to be here with you.

5 All right, let's see, where are we. Let me
6 give you a little update about what's been going on
7 since I've been here, and we want to try to make sure
8 you do have an agenda.

9 By the way, actually, let me tell you one
10 other thing -- this document I've told you about, the
11 fast facts on each of the ten initiatives, as well as
12 the ten, or the four messages is really why kind of
13 why we picked these ten initiatives, it's the "why is
14 this important, why are these the ten things we chose
15 to focus on," the overheads or the Power Point that
16 you had given out this morning, I'm going to ask you
17 to look at as the folks are presenting to you today.
18 Because they are sort of the very, very high level of
19 what we're going to try to do within each of those ten
20 initiatives, you could pick off any one of these
21 initiatives and the entire agency could focus solely
22 on that and we still wouldn't get everything done in

1 that initiative.

2 So, we are, within those initiatives, trying
3 to concentrate on, what can we really make a
4 difference in, what can really do about those ten
5 initiatives in the next couple of years. And so that
6 is how those two documents work together, and so we'll
7 be referencing those as we go.

8 The Power Point is a Power Point I've been
9 using -- or some version of it -- when I've been out
10 talking with groups, and I've gotten really great
11 feedback. And it has also been evolving, as people
12 have been providing us with input and as the leads
13 have been working on their initiative activities and
14 efforts.

15 All right, you do have in your materials the
16 agenda, so I'm going to talk just a little bit longer
17 -- but not a ton -- about, sort of, some of the things
18 that have been going on since I've been here and then
19 we will try to get on to starting with the
20 initiatives.

21 So, there's a few new people that have
22 started, and a couple of things that are changing here

1 at SAMHSA for those of you who are on the Council that
2 have been here before, we are doing a reorganization -
3 - a small reorganization -- that is moving our policy
4 efforts all into one place, a new office on Policy
5 Planning and Innovation and then we are concentrating
6 our financial efforts in one place, under Daryl's
7 shop. And so, bringing the contracts and -- what do
8 we call those things -- contracts and grants,
9 management and contracts into Daryl's shop, so that
10 all of the financial efforts are in the same place.

11 So, that's the main shift and that will be
12 effective July 1st or thereabouts. And so you can
13 watch for those changes. We also are starting to
14 pilot having regional office staffs, so those of you
15 who work with Regional Directors in the ten regions
16 for HHS know that there's never been, or hasn't been
17 recently, anyway, any SAMHSA presence, there. So,
18 unless there's a regional office person who just
19 happens to know something about behavioral health --
20 and there are some out there who do -- there's not
21 really any formal presence out in the regional
22 offices. We're trying to work on making a difference

1 about that.

2 We have detailed the person to the Dallas
3 Office as a pilot, Beverly Watts Davis, who is doing
4 our tribal affairs in HIV/AIDS has been detailed to
5 Dallas for 6 months to see if we can figure out what
6 the functions and stuff ought to be out there and that
7 it is our goal over the next two years -- slowly but
8 surely -- to move regional people out into all ten of
9 the regions. So, there will be a presence out closer
10 to where everyone is for SAMHSA and a behavioral
11 health presence in each of the regions. So, we hope
12 that is positive, it's evolving.

13 We also have some new staff. I've already
14 mentioned John O'Brien, you'll be hearing from him
15 soon. He literally got here the week health reform
16 law passed, the bill passed, and signed the next week
17 or so. His primary focus is on that reform
18 implementation and also on Medicaid and Medicare
19 issues, which is already -- but will be -- a growing
20 source of funding for behavioral health services and
21 all that that means, as well as the parity issues,
22 regulations and otherwise, and then also, frankly the

1 block grants, because the block grants will be
2 incredibly impacted by health reform and its
3 implementation, and we want to make sure that the
4 block grant is used by States for those things that we
5 know work and that cannot be funded by Medicaid,
6 Medicare and other sources. So, John will tell you
7 more about that in a minute.

8 Ben, I've already introduced to you, he
9 started on April 19th, so he actually has a background
10 in legislation and policy and speechwriting and
11 community outreach and a bunch of other things,
12 especially in seniors -- for seniors, for elderly.
13 So, he brings a unique perspective for us.

14 Steven Rendazzo, who used to work for me in
15 New Mexico, is joining us yesterday. He will be
16 helping John on health reform as well as helping Mark
17 and Elaine on social media issues. We are very clear
18 that in the 21st Century, we have got to do more about
19 getting the word out through Twittering, Facebook,
20 text, Skype, whatever else there is, for young people
21 especially but for anybody who's looking for
22 information and getting messages, we need to do better

1 about that, and Steven's going to help on that, as
2 well.

3 Sheila Cooper is our new SAMHSA tribal
4 coordinator. Sheila comes to us from the Seneca
5 Nation, and comes to SAMHSA from the Administration
6 for Children and Families, Administration for Native
7 Americans, where she held the position of Director of
8 Program Operations. She has a wealth of Federal and
9 tribal experience and we're fortunate to have her.
10 She's actually been out with me and Westley and some
11 of the other folks who are out there at the Regional
12 Tribal Consultations that have been going on around
13 the country and is just back. Those have just ended,
14 so we'll be working on what to do about that input.

15 Her position -- this is -- we now have --
16 she will also be able to do this full-time. When
17 Beverly was doing this, Beverly had other
18 responsibilities, so Sheila will be able to look at
19 tribal issues full-time and work with both tribes as
20 well as with our Tribal Advisory Council.

21 All right. We've done a whole bunch of
22 things during the first five months I've been here,

1 things and events. We've had a series of meetings
2 with mental health stakeholders, mental health groups
3 with -- I've been -- and with substance abuse groups.
4 We've had a couple of different all-hands meetings --
5 I think we've had three of them, actually, all-SAMHSA
6 staff meetings, really talk about where we're going
7 and how we're doing that, and to engage them in that
8 work.

9 We've also had some special meetings around
10 health information technology and electronic health
11 records and some special work around workforce issues,
12 two of our initiatives. And I have also, as all of
13 the staff always are, but I'm -- have been out on the
14 stump quite a bit, talking with groups all across the
15 country, about the ten initiatives, about what we're
16 trying to accomplish, about what they think we should
17 be trying to accomplish, about what they think SAMHSA
18 should be for the country.

19 And that's been a great process. It's sort
20 of killing me, but it's been great to listen, and
21 hear, and be as part of that.

22 We're also in the process of focusing on our

1 budget. Believe it or not, we are in the process of
2 looking at the budget proposals for 2012. Now, let me
3 have you think about that for just a minute. We are
4 in 2010, the 2011 budget, the President's budget, was
5 announced in February or something, proposed, it's not
6 through Congress yet, and when it will get through
7 Congress is an unknown, at this point. And then we
8 are already working on Fiscal Year 2012. Fiscal Year
9 2012 is the last year of the President's first term,
10 already. So, it's my first full budget round.

11 So, we are trying to look at making some
12 differences, and also trying to incorporate some of
13 the initiatives into our budget request. Obviously,
14 it's way too early for us to be able to talk about
15 Fiscal Year 2012. We're not done with it, and neither
16 is the Department and neither is the President. But,
17 certainly for Fiscal Year 2011 you will see, if you
18 haven't seen it already, you'll see some of the
19 initiatives reflected there, and then we hope to do
20 more of that in Fiscal Year 2012.

21 We're trying to, obviously, address the
22 treatment gap of the 23 million people who need help

1 out there, and who -- some of whom know they need it
2 and some don't. And we are also trying very hard to
3 implement our prevention initiative, which is priority
4 number one. It's the first time in my career in
5 substance abuse and mental health services that I've
6 been able to focus on prevention, and I think it's --
7 the time is now. For the first time, people get that
8 there's science behind health promotion, mental health
9 promotion, behind mental illness and substance abuse
10 prevention, and certainly about early intervention in
11 terms of reducing the impact of those early symptoms.

12 When we get to that part, I hope Fran will
13 talk a little bit about the IOM stuff and, as well as
14 our efforts at doing things like trying to reduce the
15 incidents of suicide, because so many people who take
16 that action, or think about taking that action have
17 not really been involved in the mental health system.
18 So, having to figure out ways to get that prevented
19 before people get to that extreme is important.

20 In Fiscal Year 2011, the President's budget
21 for SAMHSA represents about \$3.7 billion, it's an
22 increase of \$110 million, including a variety of

1 different funds and that's about a 3.1 percent
2 increase over Fiscal Year 2010. We think that's huge.
3 That is a huge and positive comment because the
4 President started in Fiscal Year 2011 committed to a
5 3-year process of having discretionary spending, which
6 SAMHSA is part of, flat. So, to the extent that we
7 got a 3.1 percent increase in a year when
8 discretionary spending was being held flat, we think
9 that is a very important and positive comment, and
10 evidence of support.

11 I don't know 2012 will look like at this
12 point, it is unclear about that, so we will see those
13 continued investments in 2011 in the block grants and
14 Safe Schools/Healthy Students and children with
15 families and recovery support and a number of other
16 initiatives that are new, actually, including
17 prevention-prepared communities, additional children's
18 mental health services, additional drug court monies
19 and other additional housing monies. You're going to
20 hear, I hope, about some of those things as we go
21 through this process.

22 All right, there's also a huge emphasis in

1 Fiscal Year 2011 on data collection -- new programs
2 and collaborations and performance measurement in our
3 NSDUH, which is our National Survey on Drug Use and
4 Health, on Drug Abuse Warning Network, which we call
5 DAWN, and on a Community Early Warning and Monitoring
6 System, which we've called everything from SEEMS to
7 CEMS, so SEAMS or to whatever. I'm not sure what that
8 acronym is yet. We make them up.

9 So, anyway, we're also, at this point,
10 looking at the ten initiatives, and trying to figure
11 out how all of these initiatives, how we can utilize
12 the dollars best to move these initiatives forward.
13 Hopefully, you will see more and more of these
14 initiatives incorporated into requests for
15 applications that come out and into collaborations
16 that we're doing with HRSA, with AHRQ, with CMS and
17 with a bunch of other sister agencies -- the National
18 Guard, the Veterans Administration, a lot of work
19 across the Federal Government.

20 So, about ready to be done, here, so you can
21 get started, and we just want to make sure that you
22 have an opportunity to tell us whether we're on the

1 right track and whether we're doing the right things
2 before we go too far down this road.

3 All right, I think I'm going to stop, here,
4 and let me just open it up for a second to see if you
5 have questions about the agenda. Actually, if you can
6 find your agenda in the packet, we're going to do --
7 we're just about on time, we're going to have John
8 start, and we have an -- actually, we're ahead of
9 time, I guess.

10 Okay. So, we have just a couple other
11 things -- minutes and a couple of things to do and
12 then we'll get started on health reform. So, does
13 anybody have any questions about the agenda? The
14 order we're going to go in today is, health reform is
15 first, and then prevention, and then we'll have -- we
16 have box lunch here for the Council and we'll break
17 for that and then after lunch, Pete's going to present
18 the data outcomes and quality and then Mark will do
19 public awareness and support while Fran and I go
20 upstairs and do public awareness and support. And
21 then we'll end the day with public health workforce --
22 oh, health information technology and workforce, or we

1 get Westley's -- both of Westley's -- at the end of
2 the day with a break in between.

3 We will have public comment, then, and then
4 Gil will be here to present the National Drug Control
5 Strategy, so it's a long day.

6 If you -- I think most of you know, but if
7 you don't, the restrooms are right out this door. You
8 can go out there and, this way, but there's restrooms
9 right over there. And I think that's it for
10 logistics.

11 So, any questions from any of you about the
12 agenda?

13 [No response.]

14 Chairperson Hyde: Okay. We'll talk about
15 tomorrow's agenda tomorrow. It'll be the rest of the
16 initiatives and a couple of other things, and so let's
17 get started with the minutes, which is something we
18 have to do.

19 So, all right. You should have gotten the
20 minutes, these minutes were certified in accordance
21 with the Federal Advisory Committee's Act regulations.
22 Members were given the opportunity to review and

1 comment on the draft minutes, Amber has also received
2 a copy of the certified minutes. If you have any
3 changes or additions, they'll be incorporated in this
4 meeting's minutes.

5 If not, can I now have a motion to approve
6 the minutes?

7 Ms. Stein: So moved.

8 Dr. Wang: Second.

9 Chairperson Hyde: Flo Stein moved and Dr.
10 Wang seconded. Any comments on the minutes?

11 [No response.]

12 Chairperson Hyde: Hearing none, they are
13 approved.

14 Any objections? I should have had a -- ah,
15 let's just let you have your -- raise your hands. All
16 in favor, raise your hand.

17 [Show of hands.]

18 Chairperson Hyde: All right. Seeing no
19 objections, we'll call them approved.

20 All right, is there anything else I need to
21 do before we start?

22 Okay, so just any other comments about

1 anything that I had to say? Any questions of me,
2 anything else?

3 Okay, it's time for you to stop listening to
4 me and we'll get onto -- is John in the room? Okay.
5 And Ben's not in the room, either, how did that
6 happen? We need to find John, just a minute. Hang
7 on.

8 John, you're on. You can't leave when
9 you're on.

10 PRESENTATION OF JOHN O'BRIEN, SENIOR ADVISOR
11 TO THE ADMINISTRATOR ON HEALTH FINANCE

12 Mr. O'Brien: Good morning. I am very happy
13 to be here and I'm very happy to be talking about
14 healthcare reform. As Pam had indicated, I believe if
15 I do the chronology correctly, I talked to Pam about
16 the job around January 15th. I believe on the 19th
17 there was an election that occurred in Massachusetts
18 that threatened healthcare reform. Still agreed to
19 come in the hopes that perhaps something would happen,
20 and something did happen. And so, six weeks ago the
21 President signed into law the Affordable Care Act.
22 And I think that there is great reason to celebrate.

1 This is a huge victory -- a huge victory for lots of
2 individuals, including individuals within our field
3 and whom we care about.

4 And so I'm happy to be here, I'm happy to be
5 at SAMHSA, helping SAMHSA with this initiative. I'm
6 also happy to see that prevention, mental health, and
7 addictions are a part of healthcare. One of the
8 things that I did do over the last few weeks was
9 actually count the number of times that those terms
10 were used in the bill. And although the bill is
11 voluminous and has somewhere around 450 provisions, I
12 was able to count 57 times that those terms were used.

13 Now, that is a lot, but it does pale, in
14 comparison, to, I guess, the most prominent phrase in
15 the bill which, "The Secretary shall," which was used
16 somewhere around 2,000 times. But we're in there, and
17 we're in there in some very prominent and important
18 places.

19 Let me talk a little bit about the 10 or 15
20 minutes of my presentation. One is, I wanted to
21 highlight the healthcare reform provisions that are
22 our priorities, and I say our priorities because as

1 you know, it is a pretty significant piece of
2 legislation, and what is a priority today, May 11th,
3 may not necessarily be a priority June 11th, just
4 because of some of the thinking that occurs both at
5 the Health and Human Services Secretary level, as well
6 as some other places.

7 But, at least I think we have some stakes in
8 the ground in terms of what's important in terms of
9 the provisions. I want to talk a little bit about the
10 impact that those provisions that I highlighted have
11 on mental health and addictions and prevention, and to
12 talk a little bit about the work that we think needs
13 to get done in order to be able to address and plan
14 for some of that impact. And then, I think, after
15 that we'll just have a discussion about healthcare
16 reform from the National Advisory Committee.

17 So, let me talk a little bit about some of
18 the major provisions that I think are important as we
19 think about framing our work and our discussion. As I
20 had mentioned, there was 450-plus provisions that are
21 a part of the bill, a number of them really are fairly
22 meaty in terms of the work that needs to get done.

1 Some of it is going to require a fair amount of heavy
2 lifting initially by HHS as well as, well, and SAMHSA.
3 But the ones that I think are really prominent and
4 driving some of our work is the expansion of
5 healthcare insurance.

6 The law requires that both States as well as
7 the Federal Medicaid and Medicare program expand
8 coverage, both in terms of services and individuals --
9 it's estimated that the new law will cover an
10 additional 32 million Americans, which is
11 approximately 95 percent -- if you add the 32 million
12 plus the currently insured -- 95 percent of all
13 Americans will be covered. Of those 32 million new
14 coverees, 16 million will be those individuals that
15 are 133 percent below the Federal poverty level. Now,
16 that's important, because there are a significant
17 number of individuals in that category that are
18 currently being served by mental health and addiction
19 systems that are either primarily dependent on State
20 funds, block grant funds, or other funds to be able to
21 get their care, which includes both prevention
22 services, treatment services, as well as recovery

1 services. And with the advent of this provision, the
2 financing for some of those services will be the
3 responsibility of the Medicaid agency.

4 Second is, there are a number of places in
5 the bill that seek to expand home and community-based
6 services for individuals with mental illness as well
7 as individuals with addiction services. There are a
8 number of references in the bill about prevention and
9 how prevention activities -- some of which can be
10 covered under Medicaid, some of which will be expanded
11 through some grant programs and, I can't say this
12 enough, that the focus of the bill really are that
13 mental health and substance abuse services are
14 important in the healthcare delivery system.

15 There is many provisions that talk about the
16 integration between primary care and the specialty
17 system of mental health and addictions, and so there
18 are a number of programs -- both demonstration
19 projects -- that are in the bill that seek to expand
20 what SAMHSA is doing as well as to think differently
21 about certain populations, that can benefit from this
22 coordination. Continued efforts to share information

1 between providers to ensure better care and eliminate
2 inefficiencies, this takes a whole range of different
3 types of approaches or different types of activities.
4 Obviously, the one that comes to mind and the one that
5 is really prominent is electronic health records and
6 the ability for our field to think about electronic
7 health records above and beyond where we're at now,
8 and how that is going to interface with the primary
9 care system.

10 And the last bullet, here, I wanted to
11 emphasize that, just because we got healthcare reform
12 does not necessarily mean we do need to pay attention
13 to parity. It's clear in a number of the provisions
14 in the healthcare reform bill that parity is important
15 and that parity needs to be paid attention to as
16 different programs and different projects are being
17 developed.

18 So, obviously, that's not an exhaustive list
19 of the provisions, but I think those are some of the
20 important ones that really have an impact -- an
21 immediate impact -- of what we're trying to do and an
22 immediate impact on the field. Obviously, with

1 increased numbers of individuals who are going to be
2 insured, we are going to have the need or the demand
3 for greater access. There are a number of estimates,
4 and we have seen estimates ranging from -- of the 32
5 million individuals that are going to be newly
6 eligible either through the State healthcare exchanges
7 or through the enhanced Medicaid eligibility program,
8 anywhere between 4 to 6 million of those individuals
9 will need mental health or addiction services.

10 The benefits and -- when I talk about
11 benefits, I'm talking about the services that are
12 referenced in a number of places in the bill --
13 include mental health and substance use disorder
14 services. There are a number of places, as I
15 mentioned, that have focused on prevention, treatment,
16 recovery services, rehabilitative and habilitative
17 services. That language is in a number of places in
18 the bill.

19 We, SAMHSA, I think needs to be in a
20 leadership role to be clear about what those services
21 are, what additional services should be included, and
22 frankly, what the effectiveness of those new services

1 could be. There are lots of places in the legislation
2 itself that talk about services and talk about
3 benefits packages, frankly, it gets a little confusing
4 for even me after 6 weeks, but the critical ones to
5 really mention and think about are the services that
6 will be covered by the exchanges -- those are the
7 exchanges that States develop for those individuals
8 who are not currently insured but who are not going to
9 be Medicaid eligible, who will have the choice among
10 plans of where to enroll in order to be, or from which
11 to enroll in order to get services. Those plans have
12 to provide, then, essential benefit package, in that
13 essential benefit package, there has to be mental
14 health and substance use services, there has to be
15 habilitative services, rehabilitative services and
16 medication.

17 Now, that's kind of the high-level
18 description that is in the bill. Much work has to be
19 done in order to define what those services are within
20 those larger, broader categories. For the Medicaid
21 population, the newly-Medicaid population, the 133
22 percent and below, they will have what is called a

1 benchmark plan that will be offered them. And a
2 benchmark plan generally is a plan that either the
3 State and/or the Secretary determines is similar or of
4 equal value to a plan that is currently in existence
5 that has a fairly healthy set of benefits. Again, we
6 can not define what is in a benchmark plan.

7 And then last but not least, as I mentioned
8 earlier, there is a fair amount of other provisions
9 that talk about expanding home and community services.
10 And again, some of that is fairly clear now in some of
11 the existing programs, but I believe that CMS and
12 other places are beginning to think about what other
13 types of services, in addition to what's already in
14 law, need to be part of those home and community-based
15 services.

16 There's four to five different opportunities
17 to develop integrated primary care and specialty care,
18 meaning mental health and addiction services. We're
19 going to have to develop what I call sustainable
20 models that have spreadability. Now there's lots in
21 that sentence -- sustainable, in terms of, these are,
22 in fact, integrated efforts that work. And then

1 spreadability -- now that we know that they work, how
2 do we think about moving them beyond to maybe some of
3 the grant programs or some of the other initiatives
4 that we have in place in particular areas, kind of
5 little pockets of excellence, something that exists in
6 a particular region or a particular State.

7 Policy decisions and information will be
8 moving at warp speed. One of the things that Pam says
9 -- and I completely agree with her -- is that the
10 decisions and the processes that are being used to be
11 able to develop policies are moving fast -- they have
12 to move fast. Some of the deadlines, if you look in
13 the bill, are -- have already passed, meaning the end
14 of March, as well as the end of April, and some of
15 them have lots of summer due dates. And so, again, in
16 order to be able to make those timelines -- and the
17 Administration is very adamant about making those
18 timelines -- there has to be a fair amount of thought,
19 work, effort done in a short amount of time.

20 And so, again, I think it is important as
21 those decisions become made or become drafted, that
22 there's information to folks to understand what the

1 implications are of those various policy decisions.

2 And then another impact -- and Pam had
3 mentioned it again -- that the implementation of
4 healthcare reform -- especially as we get to the
5 January 2014 mark, which is important, because that's
6 when a lot of folks who are going to be covered under
7 the 133 percent of the Federal poverty level, it's
8 going to necessitate us to rethink what we buy. And
9 right now we buy a lot of things that may be bought
10 either through the exchanges or may be bought through
11 the benchmark plans, we don't know. But we're pretty
12 confident that they will, and so we have to think
13 whether or not or how to best design services and buy
14 services that kind of wrap around those plans, or how
15 we think about buying services that folks need who
16 might not necessarily have coverage -- either because
17 it's episodic, they lost their coverage, or maybe they
18 weren't covered as part of that 90 -- they were the 5
19 percent that wasn't covered.

20 So, those are the impacts. So, I wanted to
21 talk a little bit about what is the work that needs to
22 get done? And again, what I've done, here, is to

1 actually set up a number of the future speakers around
2 the areas that healthcare reform impacts some of what
3 they're doing. Obviously, with 32 million people
4 eligible or newly eligible for insurance and services,
5 we will have an access issue that we will need to
6 address -- that's already on top of the treatment gap
7 that we have. And so we need to think about smart
8 ways to prepare the field in order to develop the
9 capacity to provide mental health and substance use
10 services. And I know Dr. Clark is going to talk a
11 little bit about that.

12 The second is accessing and developing
13 strategies to improve infrastructure. There is going
14 to be a number of changes that are going to occur as
15 it relates to what I call plumbing. So, there are a
16 number of our providers -- our specialty providers who
17 do really good work, but who have never had to deal
18 with insurance companies, never had to do with
19 Medicaid, and so they need some help figuring out how
20 to do that, and how to submit a bill and how to make a
21 payment, and how to get a payment, and how to keep
22 their payment once they get it. So, that's important.

1 And then, I think, States need to have
2 information -- the State substance abuse authorities
3 and State mental health authorities are going to be, I
4 think, important conduits to be able to find
5 individuals over the next several years who are going
6 to be eligible and to encourage them to enroll. I
7 also think that it's going to be important that they
8 also have data systems that are going to be comparable
9 to some of their Medicaid counterparts -- especially
10 if they're thinking about buying services differently.

11 Third, and lastly but not least, is this
12 facilitating linkage with primary care and other
13 providers. There's a provision in there that requires
14 SAMHSA to be part of what is known as health home
15 applications from the States to CMS. We are expanding
16 on our primary care initiatives and I also want to
17 say, we'll be participating with CMS around special
18 needs plans for dual-eligibles.

19 Let me just say one little word about dual-
20 eligibles, and that's dual-eligibles for Medicare and
21 Medicaid. You know, I always knew they were
22 important. I went to a meeting last week, and the

1 amount of money that is spent on dual-eligibles, that
2 is, Medicare and Medicaid payments in 2008 was \$307
3 billion. Think about that, \$307 billion. And a lot
4 of that is being spent on medical care, but a lot of
5 that is being spent on long-term and institutions. Of
6 the individuals who are dual-eligible, almost 60
7 percent of those individuals are under the age of 65
8 and have either a mental impairment or a cognitive
9 impairment. So, CMS and we are very concerned about
10 how we think about those numbers, how to think about
11 those services, and what are the right strategies for
12 those individuals as we move forward over the next
13 couple of years.

14 A couple of other things are identifying
15 services that represent what I call a good and a
16 modern mental health and addiction services -- it's
17 going to be foundational work as we begin to think
18 about the discussions around benefit packages, the
19 three or four types of benefit packages that
20 healthcare reform talks about the need for. I think
21 we have to be clear what needs to be in there, we have
22 to be at the table talking about that. And I will say

1 our field has been not-so-clear sometimes around what
2 that benefit package should look like. And I think
3 we're going to have to bring some clarity, otherwise
4 other people are going to be defining that for us if
5 we're not clear about that.

6 In addition to the benefit piece, or at
7 least in addition to defining the services for the
8 benefit piece, we also wanted to be having discussions
9 with CMS around those services that -- as it relates
10 to regular State-planned services. Those services, as
11 it relates to home and community services. Also,
12 frankly, to have the conversation with them and
13 ourselves and others about those benefits as it
14 relates to Olmstead lawsuits, as well as kids EPSDT
15 lawsuit for mental health and addiction services.
16 There are a number of places that have already entered
17 into litigation, there are a number of places that may
18 be at risk of, and I think we need to be clear what
19 benefits make sense for those two efforts.

20 And then the last two things are, reviewing
21 the currently block grant spending, recognizing there
22 may different services and supports we may want to buy

1 with it, given what may or may not be covered under
2 healthcare reform and we want to be thoughtful about
3 those services, and we also understand that
4 transitioning systems -- especially State systems that
5 are reliant on some of these block grant funds for
6 services is going to need to be a discussion with some
7 of our partners at the State and Federal level.

8 A couple of other things I'll mention is
9 that we, in addition to defining or addressing what is
10 a good and modern system of mental health and
11 addiction services, we know there's some work that
12 needs to get done around some of these other service
13 areas. And so we want to drill down a little bit on
14 some of those services so we can develop some possible
15 definitions around prevention, around recovery, around
16 consumer-operated services and wrap-around services.
17 So, when we talk about those services as a field, that
18 there's some frame for it and that as the benefit
19 plans change because -- for instance, in the central
20 benefit plan, the Secretary can add benefits on an
21 annual basis. We might have, you know, enough
22 information, enough good evidence that we can add

1 benefits as time goes on -- and we should, I mean,
2 that's -- the benefits package shouldn't just be
3 whatever it comes out to be in 2014.

4 Last, but not least, point, States,
5 providers, and individuals, and families to understand
6 the changing environment, trying to get information
7 out there that's real-time. We know already, we've
8 been talking to a number of stakeholders' groups, it's
9 confusing and we're going to hopefully try to make
10 some sense of it. But, again, it's really fairly
11 large, and we're sitting at the table. There's six
12 workgroups within HHS that just started: Prevention,
13 workforce quality, long-term care, the exchanges
14 themselves, and transparency and anti-fraud, which is
15 really around -- or at least for, as we're concerned
16 about compliance with various Medicaid and Medicare
17 pieces.

18 And then there's a Coordinating Council that
19 really rests above all of those that we are on and who
20 really help think through some really difficult policy
21 decisions. I've got to tell you, you know, sitting in
22 that room, I'm impressed with how brilliant and smart

1 these people are -- present company excluded -- but
2 that, you know, these people have been doing
3 healthcare reform most of their lives, some of them
4 were doing healthcare reform in the early nineties.
5 And, you know, as rapid as this is happening, I'm
6 comfortable that there are some really good decisions
7 being made.

8 So, let me stop there and open it up for
9 questions and discussions.

10 Chairperson Hyde: Before we open up for
11 questions, let me just remind you on your Fast Facts
12 sheet, on page 6 is the Fast Facts having to do with
13 health reform. And on slide number nine, not -- well,
14 actually it starts on slide number 8, not page but
15 slide -- and the numbers are actually up in the little
16 black box in the sort of upper fourth right-hand -- do
17 you see that? Can you -- do you see the number of the
18 slide? It's how we reference them. So, the
19 Affordable Care Act is the name of the law that
20 encompasses both of the bills that passed and were
21 signed. So, there's a few overheads there that also
22 summarize a couple of things and the reason I'm

1 pointing this out to you is there's a couple of
2 things, starting on slide 14, that have 2010 by them.
3 So, there's a lot of stuff going on in 2010, right
4 now, even though some of the stuff goes -- happens in
5 2014. And States are being given the option to do
6 things like high-risk pools and things like expansion
7 of kids being allowed to stay on their parents'
8 coverage to age 26, and even States options to start
9 covering some of the under 133 percents already out
10 there.

11 So, stuff is moving very fast, so I think
12 that -- those may be helpful things for you to look
13 at, as well.

14 Okay, the floor is open to the Council for
15 questions, comments, thoughts, Judy I see you leaning
16 toward the mic. Go for it.

17 Ms. Cushing: Just a question of John
18 regarding prevention. There's a lot of mention of
19 prevention in healthcare reform. My question is, is
20 there real primary prevention included in this? There
21 appears to be secondary and tertiary. But the front-
22 end prevention that's really going to stop something

1 before it's happening, those young children that
2 Marvin was referring to earlier, who are at highest
3 risk, and families who are at highest risk.

4 Mr. O'Brien: Yes, as a matter of fact,
5 there's been some discussion around kind of what is
6 the breadth of the various provisions around
7 prevention. And there have been lots of discussion
8 about primary versus secondary versus tertiary and
9 again, it's one of the pieces of work that is the
10 responsibility of the prevention HHS workgroup. And I
11 know, the meetings have just started either last week
12 or this week.

13 And Fran, I don't know if there's anything
14 from those meetings yet, they're generally just been
15 to get organized one, but that issue is front and
16 center.

17 Ms. Wainscott: I'd like to ask Council
18 members, in your State is your substance abuse
19 treatment agency going to be useful, do you believe in
20 identifying people that are part of the newly 133
21 percent?

22 Chairperson Hyde: Cynthia, could I just

1 make sure -- remind people who they are, because
2 there's a whole bunch of people listening and
3 watching, so just --

4 Ms. Wainscott: Sure. Cynthia Wainscott.
5 The reason I'm asking the question is, I don't think
6 in my State that's a reality because of the limited
7 touch in the community. And it seems to me that from,
8 I would guess, let's see what you all say, that
9 community agencies might be better at that than the
10 State mental health authority.

11 Chairperson Hyde: John, do you want to
12 comment on that? And, I think the question was to the
13 Council, but --

14 Mr. O'Brien: I do. And, Cynthia I --
15 having worked in your State for awhile, I can
16 appreciate that, but I also know that the information
17 that the State authorities are going to need to help
18 with enrollment is going to be helpful in prompting
19 providers to do exactly what it is that you're
20 suggesting.

21 In some respects, you know, this is going to
22 be a big shift for providers, many of whom, at least

1 in the addiction side, had been used to, maybe,
2 getting their one-twelfth grants, on a monthly basis,
3 in order to be able to, you know, pay for services.
4 And so, now it's going to be a little bit of push.
5 And I think that little bit of push is going to have
6 to come from the State SSAs to say, "Listen, of the
7 300 people or 400 people that you're surveying, you
8 know, 200 of those individuals probably could, and
9 should enroll in the new expansion program. So, I
10 think it's the SSAs with the data, pushing the
11 providers in terms of really helping individuals
12 enroll. So that's kind of where I was going on the
13 SSA and data piece.

14 Chairperson Hyde: I think Flo has a comment
15 on this.

16 Ms. Stein: Yeah, I understand that one
17 State is one State, but we've already done this data
18 analysis for our mental health and substance abuse
19 populations to provide to providers, but even most
20 importantly and much sooner, to our State legislature
21 that goes in session next week, because they already
22 want to know where the shift is going to come in the

1 State appropriation. And so we, our first data
2 venture, we have not as many as we would have thought,
3 but about 50,000 people who can go in the benefit at
4 the 133 percent of poverty for Medicaid, and so we're
5 going to start talking about that with our
6 legislation. So, I think those questions are going to
7 be answered by somebody very soon in your State and we
8 all have to be a part of that.

9 And I just wanted to say that I really
10 commend what you are already doing to provide
11 leadership around these benefit designs because
12 they're critical. For once, we're going to sort of
13 have to be on the same page, and we need your
14 leadership. It -- even in North Carolina I think
15 we're kind of a little bit, we've really been
16 proactive about this, because we have a big prominent
17 school of public health whose been working on this for
18 years. When you have groups looking at the whole
19 health reform is really easy for the behavioral health
20 benefit to kind of get lost or short-shrift, which is
21 why I think we need some National leadership around
22 it, and I appreciate your plan.

1 Chairperson Hyde: I think the question goes
2 to two parts, if I'm correct, Cynthia, and then George
3 had his hand up. One is, the people that are
4 currently getting services through some other method
5 than Medicaid, who will be eligible for either
6 Medicaid or an exchange later. So, part of it is the,
7 how do you get them moved over to eligibility. The
8 other part of it is, that whole group of people who
9 aren't getting care anywhere. Who are on the streets
10 or who are, whatever, and aren't in our systems, yet,
11 and may need to be made eligible to get services. Is
12 that right, Cindy?

13 Ms. Wainscott: Exactly. And the people in
14 the homeless shelter who have received no treatment at
15 all are not in contact with our State agency. And
16 you're right, Flo, every State is every State. We're
17 going to need some really creative processes, I think,
18 though.

19 Chairperson Hyde: I think George was next,
20 and again, if you could say your name and maybe your
21 State, just so the people listening kind of know the
22 perspective you're coming from, geographically.

1 Mr. Braunstein: George Braunstein,
2 Virginia.

3 I, actually, I am more concerned -- I do
4 believe that the case finding will likely be a mix of
5 both the local and State agencies going after.

6 But, I think that I'm more concerned with
7 where local, public, and private agencies -- probably
8 more public agencies that are the safety net -- will
9 end up finding -- will get the technical assistance
10 they will need to be able to manage under this kind of
11 system because the most public agencies are losing
12 funds that they were heretofore getting, or there are
13 significant cutbacks of some sort. So, I think that
14 it will be interesting to see where the technical
15 assistance comes from

16 I had a question that goes, I think, goes to
17 that. Can you speak a little bit about the concept,
18 and how it will play out for accountable care
19 organizations?

20 Chairperson Hyde: John, can you comment on
21 the technical assistance first?

22 Mr. O'Brien: Sure.

1 Well, a couple of things, with the technical
2 assistance piece, one of the -- the way we kind of
3 organized our work is, initially, that the work kind
4 of falls into four buckets. One is, what do we need
5 to do at the national level around some of our
6 responsibilities as it relates to healthcare reform,
7 and then some things we think are important to drive
8 some of the decisions, and then we have three other
9 buckets, which are technical assistance to, kind of,
10 State and local authorities, technical assistance to
11 providers, and then technical assistance to consumers
12 and families. I will talk a little bit about the
13 technical assistance to providers, because some of
14 what you've just said is one of the things, I know,
15 that keeps us up at night, and others around the table
16 up at night. And that is, some of them, again, have
17 not had a lot of experience with interfacing with
18 third-parties' insurance, whether it's public or
19 private. And so, for those who can and should,
20 there's going to need to be some assistance with that,
21 and we're actually bringing in the provider
22 associations to talk about what are some sensible

1 strategies to begin to think about addressing some of
2 the infrastructure issues and some of the training
3 issues that relates to the infrastructure issues.

4 The other thing that's important, as well,
5 is that not all of the services are necessarily going
6 to be covered by the exchanges, or by Medicaid. And
7 so that there will be a need for continued services
8 that will support individuals, some of which, again,
9 won't lend themselves well, and shouldn't lend
10 themselves well, to traditional payment mechanisms
11 like fee for services. And so that, the need for
12 continued grants, especially around things like
13 capacity, crisis services and some other things are
14 going to still need to exist. And, I think on a
15 State-by-State basis, they're going to have to make
16 some good decisions about, kind of, what do we pay for
17 what's going to look more like a traditional benefit
18 package and what do we keep in place in order to make
19 sure we have that safety net.

20 Chairperson Hyde: Kate, I believe you were
21 next?

22 Ms. Aurelius: In regards to people's

1 concerns about finding folks to go into Medicaid,
2 Arizona has had an expanded Medicaid program -- up to
3 100 percent of poverty level -- since 2002. And my
4 advice is, partner now with the medical side, because
5 what's been happening, of course, to people who aren't
6 Medicaid is they have some access to behavioral health
7 services and no access to medical services. And the
8 hospitals, particularly, are eager to find payers, as
9 are you.

10 There are electronic tools for eligibility
11 determination. We, in Arizona -- it has been well-
12 documented -- is having the biggest percent structural
13 deficit in the country, and we're down 33 percent on
14 our eligibility workers, and our population's up at
15 least twice that. So, managing with electronic
16 process and partnering with community partners, it's
17 not only mental health providers who want to get
18 people in.

19 Chairperson Hyde: Good comment.

20 Judy?

21 Ms. Cushing: Cynthia, to your question
22 about are States prepared, and Flo's comment, each

1 State is each State, but last September, though, the
2 Council had the opportunity to hear from Dr. Bruce
3 Goldberg, who is the Director of the Department of
4 Human Services in Oregon, is now also the Director of
5 the new Oregon Health Authority that was mandated by
6 the legislature two years ago. And he described to
7 you the complexity of the reimbursement system and --
8 which is currently designed to follow funding streams
9 and lacks standard payment schedules, et cetera.

10 But the goal of the new system in the Oregon
11 Health Authority is to allow data to drive elimination
12 of the disparities to access to care, for all of those
13 in mental health and substance abuse -- those
14 individuals needing those services. So, a higher
15 quality of care for everyone.

16 And understand that Oregon's been a little
17 bit ahead of the curve, the former Governor was a
18 physician, and so we're already serving about 30
19 percent of the population, but we have a long, long
20 way to go.

21 I just think it's interesting that the whole
22 idea is to drive the cost down, here. By creating a

1 new authority, following along with Federal healthcare
2 reform that is going to really integrate the services,
3 require everybody to work together to provide access
4 to care to everyone for mental health and substance
5 abuse, with substance abuse disorders and needing
6 those services.

7 The providers are going to be the last to
8 come along, however, I mean, they're -- it's a whole
9 new system. And I think, you know, time will tell
10 what happens, and I would be happy to report back, or
11 better yet, it would be wonderful to have Dr. Goldberg
12 come back after a year and see what's working and what
13 isn't. Is it the magic bullet? No. But, at least
14 it's a very proactive measure by one State.

15 Chairperson Hyde: You know, John had
16 mentioned that we are bringing together our provider
17 groups to talk to them about the challenge that they
18 are going to have as this stuff shifts, everything
19 from enrollment issues to billing issues, to plumbing
20 issues as John called it, to just understanding,
21 frankly, the changes we're going to make to the
22 funding streams.

1 So, we are calling them together, and
2 obviously, to the extent that you have [indiscernible]
3 us, I will continue you through the day, is that the
4 right thing to do? Are we doing the right things? We
5 also are pulling together the State people. So the
6 NASADAD, the NASMD, the NASMHPD, which are the
7 Medicaid drug directors, the other health directors
8 and the substance use directors, commissioners,
9 whatever they call themselves, different things -- and
10 just talking at the State level, what are those three
11 State groups doing together to make sure that we move
12 into this time in a concerted way.

13 We're also bringing consumer groups together
14 that will tell about the initiatives, but will also
15 talk about, just, health reform and what we can help
16 them with, consumers and families, so they know -- we
17 know what they need to know, going through this
18 process.

19 So, those are some of the efforts we're
20 making, and if there's other things, you should let us
21 know about that.

22 Arturo?

1 Mr. Gonzales: One of the things that we've
2 been looking at, or the concern in New Mexico is some
3 of the health leaders are not, at least at the local
4 level, not moving to do anything with respect to
5 looking at initiatives or waiting for the Federal
6 guidelines to come down, the technical assistance to
7 come down. And there's a real concern that what --
8 whatever's been done up to this point, that the safety
9 net not be destroyed through whatever changes or with
10 new enrollees coming on board.

11 And I think it's real important, when you
12 talk about going out to groups, or whatever, that you
13 get the legislators involved, the key legislators in
14 the States. New Mexico has a number of key
15 representatives and legislators, as you know, and that
16 focus on these issues -- and the Governor's already
17 set up a task force for healthcare reform -- those
18 States that have those, I think it would be good to
19 get those people in to talk about how this initiative
20 is going to affect the current Medicaid programs,
21 particularly because New Mexico is in the millions of
22 dollars in the hole with regard to Medicaid, and some

1 States are looking at this initiative as, how are we
2 going to replace the dollars we've already lost, or
3 how are going to take care of the need?

4 I mean, we're already at 132 percent of
5 poverty -- we're already there. And expanding the
6 program. So, legislators, you know, are going to be
7 looking at how the money -- how to cut -- we've got to
8 balance this budget. And to get some of these things
9 implemented, I think the legislative viewpoint is
10 going to be very, very understanding of what's trying
11 to be done, it's going to be very important if they're
12 going to support it at the local level.

13 Chairperson Hyde: Thanks, Arturo.

14 In fact, you reminded me -- we actually said
15 at one point that we would try to reach out to
16 Insurance Commissioners, because they're going to have
17 a huge role in the health insurance exchanges. And I
18 know from Mexico -- and they might not always have
19 their head wrapped around the behavioral health
20 issues, as they think about exchanges and those kinds
21 of things -- nor will they necessarily have their
22 heads wrapped around coordinating with eligibility

1 requirements for Medicaid.

2 In fact, Kate, you may have a comment on
3 this. I don't know if you've experienced it in
4 Phoenix, but -- or in Arizona -- but how they put
5 together the eligibility for the insurance exchanges
6 with the eligibility for Medicaid, I think, is going
7 to be a big issue. But, you're also recommending
8 another group that we reach out to, the legislators
9 or, like, national legislative councils and stuff like
10 that, okay?

11 Did you have a comment about that, or --

12 Ms. Aurelius: No, we're just wondering
13 who's going to be the exchange, and hoping it's not
14 Medicaid.

15 [Laughter.]

16 Chairperson Hyde: There are some States who
17 would like it to be Medicaid because they're going to
18 have to coordinate these eligibility requirements.

19 All right, Ed?

20 Dr. Wang: Yes, actually, I have a two-part
21 question for John and also, actually, for SAMHSA, as
22 well. First of all, welcome to Washington, D.C.

1 Mr. O'Brien: Thank you.

2 Dr. Wang: I'm from Boston, so -- the first
3 question I have is, in terms of just to -- maybe you
4 can elaborate a little bit more when you say
5 sustainable models that have spreadability. I'm just
6 curious, in terms of the division of SAMHSA and your
7 experience in regard to, let's say, between now and
8 2014, how is that going to work?

9 Mr. O'Brien: Well, a couple of ways. One
10 is, you know, again I can say this because I'm new, I
11 can use that new card for a little bit, but it's also
12 been my experience with some other places -- I've done
13 a lot of work with, for example, the Robert Wood
14 Johnson Foundation, they were quite good at conceiving
15 what things should look like, quite good at given a
16 grant to a provider or to a community to get things
17 going, pretty good at being able to collect data that
18 shows that it works. And then in the fourth or fifth
19 year, or at the end of the grant, we think about
20 sustainability. And so, the way that I think about
21 what needs to get done is, if we've got some projects
22 going that actually show some promising practices, the

1 extent to which we think about sustaining them.

2 So, number one, we get more information, and
3 then number two, how do we think about moving it
4 beyond just the community -- the dozen or so
5 communities that we've given grants to in order to be
6 able to do a particular practice.

7 The pressure is on, as the primary example
8 is the primary care intervention piece that is
9 highlighted in the legislation, and it requires SAMHSA
10 -- once we get appropriations, to kind of spread above
11 and beyond what we're doing this year around that.
12 And so, we're going to have to figure out how to do
13 that and how to bring some of those things to scale
14 pretty quickly in the next couple of years. And so,
15 when I talk about sustaining and spreadability, it's
16 really more around planning, once we get the
17 appropriation order, to be able to figure out how to
18 do this in a way that makes sense. We can just,
19 obviously, give out more interface and hope for the
20 best, or we can figure out how to do collaborations
21 for those that get the new money in order to make sure
22 they have a good sense of what the people who did

1 something the year before, the year before that did so
2 they don't repeat the same mistakes, and they build
3 off of the good things that some of the other previous
4 grantees did or didn't do. That's kind of the answer
5 to that question, or at least my answer to that
6 question.

7 Chairperson Hyde: Ed, let me just add to
8 that and also give you some information and maybe get
9 your input about something. At some point, I want to
10 make sure that we talk a little bit about block grant
11 issues and your thoughts about that, but there's a
12 couple of things.

13 Obviously, SAMHSA is very well-versed and
14 has a lot of experience in giving out grants, making
15 sure we evaluate what they're doing and whether
16 they're good or not, and what kind of models emerge,
17 and then sort of replicating that with other grants or
18 technical assistance centers or whatever, so building
19 on that is something we are continuing to do. We will
20 soon be -- we're trying to work with partners like
21 HRSA, for example, and AHRQ. These are two other
22 Federal agencies that are interested, for example, in

1 the primary care and behavioral health integrations
2 and rather than us just doing a technical assistance
3 center, we're trying to see if we can either go with
4 them to do a technical assistance center or at least
5 partner with them so that their work is collaborated
6 in collaboration with their work. And I think you
7 will see that begin to emerge from our RFAs and some
8 opportunities and stuff like that, so that's one way.

9 And then the other way goes to the block
10 grant issue, which is, maybe this is a little too bold
11 to say, but if we're going to get your input we need
12 to do it, and that is, we have some programs that we
13 know work. And we've had lots of experience with them
14 working, but we're still funding them, largely,
15 through what we call discretionary grants, or not-
16 block-grants. And so we give money for 3 years or 4
17 years or 5 years, and then unfortunately, the way our
18 funding happens, it goes away. And so, either we have
19 to ask the grantees to come up with sustainability
20 plans -- and some of them do, but some of them go to
21 their State. And, unfortunately, now is a hard time
22 to go to a State, because there's just not money

1 there.

2 So, part of what we're trying to look at is
3 for those things that we already have pretty good
4 evidence that they work, but we're funding them,
5 largely, through discretionary funding, we're thinking
6 about how we might move that into the block grant in
7 some fashion.

8 So, those are some things we're trying to
9 think about as we rethink block grant. Because we
10 don't want to, again, that money to fund things that
11 now may be shifted to Medicaid or the exchange plans
12 or whatever. And at the same time, we want to
13 understand what we have learned in our discretionary
14 spending, that is time to say to the States, "Well,
15 you need to do this everywhere. You need to have some
16 capacity to do this everywhere." So, we're kind of
17 thinking about those issues and your input about that
18 would be helpful.

19 Arturo, then Kate.

20 Mr. Gonzales: I'm extremely encouraged by
21 that approach that you're thinking of taking. I think
22 there are some things to the discretionary programs

1 that SAMHSA has funded that have proven very
2 effective. They're expensive, but they've proven
3 effective. If I can use SBIRT as an example, and I
4 know that HRSA has been working on some integration of
5 primary care and behavioral health and I think it is
6 real encouraging that SAMHSA be at the table, as you
7 say, in this planning process because a lot of dollars
8 are going to come down for community health centers
9 and those are going to be significant dollars, and
10 HRSA is now going to be under the gun to be looking at
11 integration of primary care and behavioral health when
12 SAMHSA's already done that in some of their
13 discretionary programs.

14 And I believe that HRSA doesn't have to
15 reinvent the wheel if SAMHSA's at the table saying
16 that this works, and this is what you get for the
17 dollar. And then I think that's really important,
18 otherwise they will go off, possibly, on a tangent and
19 are doing things totally different. And the things
20 that SAMHSA funded go by the wayside.

21 So, I think that's real encouraging and
22 important, that SAMHSA's represented there, but also

1 the block grant issue you're talking about, I think,
2 has a significant impact on sustainability of those
3 programs, and I think it needs to be addressed.

4 Chairperson Hyde: Well, you'll be glad to
5 know, we met our leadership team, met with HRSA's
6 leadership team just last week, talking about these
7 issues. They're very focused on SBIRT, an expansion
8 of that, using that as a model, and they're very
9 collaboratively working with us on the integration
10 issue because we have money to integrate primary care
11 into behavioral health, and they have money to
12 integrate behavioral health into primary care. So,
13 we're trying to marry up to see how we can do that bi-
14 directionally, if you will.

15 Kate?

16 Ms. Aurelius: It would also be helpful if
17 best practices that are identified by SAMHSA become
18 covered services by Medicaid. That has long been a
19 frustration where Medicaid and -- at the Federal
20 level, it's a medical assistance service, and they
21 don't translate that into mental health services, and
22 so you have a demonstrated model that is going to

1 cover people up to 133 percent, and in addition to
2 covering the people, the services need to be covered,
3 as well. And some -- that is State discretion, and
4 that's going to be a problem with State budgets. But,
5 hopefully, CMS is hearing SAMHSA at those tables.

6 Chairperson Hyde: Kate, with your
7 experience with mental health and Medicaid, do you
8 have a particular set of services? I know that best
9 practices covers a lot of things, but other things,
10 especially, that you think if we could show the cost?
11 Because I know Medicaid struggles with cost, that is
12 part of their -- as the name of your agency is clear -
13 - is there some specific things we can try to make
14 sure we look at and get the data and show the data
15 that these kinds of services are, in fact, cost
16 effective? Are you aware of those things?

17 Ms. Aurelius: I am. Life could be a lot
18 easier around rehabilitation services delivered by
19 peers, community lay people -- last night, Dr.
20 Gonzales and I were talking about Promathorda [ph.] as
21 a very effective model. Medicaid typically requires
22 that providers be licensed by the State. These are

1 not, necessarily, licensed people, they may be
2 accredited or certified, but I'm more -- you know,
3 Medicaid thinks of medicine, and medical, and doctors,
4 it doesn't think of peers and lay people, which are
5 obviously cost-effective resources.

6 Chairperson Hyde: Plus, more from that
7 later. Kate will be a good ally on that.

8 Stephanie?

9 Dr. LeMelle: In terms of specific services,
10 I think, from the clinical perspective, one of the
11 things that we always come up against is, when we're
12 trying to integrate substance abuse and medical care
13 in a mental health setting, the time you spend doing
14 the other assessment is not covered. So, if I'm doing
15 a substance abuse assessment on a patient in a medical
16 clinic, my time's not covered -- I mean, in a
17 psychiatric clinic, my time is not covered for doing
18 those assessments. So, doing any sort of metabolic
19 assessment, doing substance abuse assessments, doing
20 developmental assessments, doing educational
21 assessments -- those aren't routinely covered. So, if
22 there was a way to incorporate that in the coverage,

1 that'd be great. Reimbursement coverage.

2 Chairperson Hyde: Cynthia?

3 Ms. Wainscott: I think animation is our
4 biggest opportunity in healthcare reform. The things
5 we've been talking about that all relate much to it.
6 I would like to heartily, and enthusiastically, and
7 with the support of George's Mental Health Planning
8 and Advisory Council, endorse the idea of the block
9 grants being used in the way you described -- to move
10 forward, and to sustain best practices. And years
11 ago, when I was in an earlier term on our Planning and
12 Advisory Council, we actually made a formal
13 recommendation to SAMHSA that there be a prevention
14 set-aside block grant -- set-aside in the block grant
15 -- in order to say to the world, "This is important,
16 and you need to be doing it." We think that is an
17 essential function of SAMHSA, specifically the
18 Center for Mental Health Services, and we think
19 the idea -- we have said, formally, that we think
20 the idea of doing that is really a good idea.

21 And the third thing I wanted to say is
22 that I also heartily endorse the idea that you're

1 getting together with the service providers to
2 think about how we move together to do our best
3 job with healthcare reform.

4 But I think there's another thing we need
5 to do, and that is, get the payers together,
6 formally, at the national level and somehow filter
7 that down to the State level.

8 A few years ago, I participated in a
9 conference that SAMHSA had and invited all of the
10 State mental health directors, and all of the
11 State Medicaid Directors. And a surprising number
12 of them came. And it was one of the richest
13 discussions I ever heard of State-level
14 authorities -- everybody had their own part of the
15 elephant they were describing. But at the end of
16 it, they had a whole lot better idea how their
17 peers saw it, and I saw some really positive
18 things happen in Georgia as a result of that.

19 So, I think if you can somehow make that
20 happen at the National level, and filter it down,
21 that would be a huge help as we move forward.

22 Chairperson Hyde: So, I know there used to

1 be a jointly funded meeting of behavioral health
2 Commissioners and Medicaid Commissioners. I think
3 that doesn't happen or hasn't happened in the last
4 year or two. Does anyone -- do you guys know about
5 that?

6 Ms. Wainscott: We're having it.

7 Chairperson Hyde: So, maybe only bring the
8 State folks together at the association level, we can
9 have a conversation about that possibility.

10 Ms. Wainscott: Yeah.

11 Chairperson Hyde: Okay.

12 All right, Arturo?

13 Mr. Gonzales: Just following up on the
14 comment about the payers, I think that's a real needed
15 kind of thing, particularly around, you know, how are
16 you going to get some of the people that may need
17 substance abuse services and the outreach that's going
18 to be done. Well, it's going to be done, I think, a
19 large part of it, through medical homes, primary care
20 clinics. And I think, adoption -- SAMHSA's -- for
21 lack of a better word, pressure or encouragement --
22 for States to adopt the CMS codes for screening and

1 brief intervention is going to be very important in
2 that process. And -- but part of that is to get the
3 payers together to understand what that really means.

4 You know, on the adoption of those codes, I
5 know that -- not to take away her thunder, but Dr.
6 Larke's been working with that with Tennessee and
7 Virginia, and the discussion of the payers is, once
8 you understand what you're doing, then we're more
9 likely to try to start reimbursing for those
10 behavioral health services that they understand are
11 being delivered by licensed, credentialed individuals
12 from the behavioral health side, rather than simply
13 paying it from the primary care doctor side. And
14 that's going to be important for sustainability.

15 Chairperson Hyde: Okay, good.

16 Yeah, Don? Don or Donald, what do you -- ?

17 Dr. Rosen: Don.

18 Chairperson Hyde: Don.

19 Dr. Rosen: I just wanted to follow-up on
20 Stephanie's comment. She was talking about payers
21 that will pay for one set of services but not another
22 that you're compelled to provide. Access is another

1 prob -- is another issue. For instance, there will be
2 patient who come to me who can't go to primary care
3 providers. They'll come to me, and so I will feel
4 compelled to do the metabolic test and take care of
5 their hypertension and their diabetes, knowing that
6 I'm going to be covered for it, because they're not
7 going to be able to get access to it any other place.

8 Chairperson Hyde: Okay.

9 Marvin, I think you're next.

10 Mr. Alexander: I just want to thank Kate
11 for her comment, and when you asked about services.
12 Because I think that also, the youth-21 population --
13 we talk about peer-to-peer support, we're usually
14 talking about adults peer-to-peer support. We don't
15 look at mentors or young people being able to provide
16 support to other young people.

17 In my community, we've been able to pilot
18 the use of mentors in lieu of more clerical LCSW/Ph.D.
19 people. And what we found is that, a lot of times,
20 mentors are better able to connect with young people.
21 And it's not that families or young people care about
22 your credentials, LCSW or Ph.D., but, you know, what's

1 the level of connection?

2 I think that when we talk about peer-to-peer
3 support, we also need to look at families, you know,
4 how could families provide support for other families
5 that's providing care for a child or a young person
6 with a mental illness.

7 And also, young people. You know, how do we
8 also focus on young people?

9 Chairperson Hyde: Okay, great. Thanks.

10 Let me jump in here, if I can -- Terry, we
11 lost him on the audio, but he's getting through the
12 web.

13 So, he has a question about, tribes are not
14 currently eligible for the block grants, despite our
15 population, being counted when States get their funds.
16 Will SAMHSA support direct access for tribes?

17 I take it that, Terry, that's a comment that
18 we should support grant access for tribes.

19 This issue has come up a lot in our tribal
20 consultations, and there's sort of two pieces to it.
21 One is whether or not States are, in fact, providing
22 enough of the block grant dollars to serve tribal

1 people, or the members, either on reservation or
2 urban, non-reservation individuals. And so, that's
3 one issue that we're sort of looking at and the other
4 issue is this issue of a direct block grant, or direct
5 grants to tribes for services.

6 So, we are looking at both of those issues
7 but we don't have our final decision, exactly how we
8 are going to address that piece of input we've been
9 getting -- Sheila Cooper and I mentioned earlier -- I
10 don't think Sheila -- Sheila's not here today, is she?
11 I think she's still out on the road with consultation
12 stuff. But, at any rate, Sheila and I have our people
13 in the Centers and elsewhere have been -- that are
14 working on travel issues, have been thinking and
15 looking at our response, or what we need to do about
16 that kind of input we've been getting from the tribal
17 consultations. So, I just wanted to let you know from
18 Terry's comment.

19 Okay.

20 Ms. Stein: I wanted to second what Marvin
21 said about families. That was not what I started to
22 say, but especially in DD, I know that's not mental

1 health and SSA, but we are definitely moving back to
2 families, and families as primary care givers, and
3 supporting that to do that. And that may be, also, a
4 good service for -- especially people with serious
5 mental illness who need a place to live and be in the
6 community but we're not going to be able to use 24-
7 hour services to support them.

8 I wanted to ask John, if you could say a
9 little bit more about health home, and health home
10 application?

11 Mr. O'Brien: I can.

12 There's a provision in the law that requires
13 or -- yeah, it requires CMS to develop both grants for
14 health homes, as well as a process for State Medicare
15 agencies to amend their State plans to include health
16 homes. And they have identified several things in the
17 bill that are directly related to defining health
18 homes.

19 One is, who would be the intended population
20 of a health home and in the legislation they
21 specifically say that individuals that have two
22 chronic conditions -- one of which could be addiction

1 -- would be targeted recipients for the health home.

2 Or, specifically saying that individuals
3 with serious and persistent mental illness, in and of
4 itself, could be a reason, or would be one of the
5 intended recipients of a health home.

6 They have identified health homes pretty
7 broadly, and so some additional work, I think, needs
8 to get done. One is, they talk about health homes and
9 the agencies that can be health homes and they get
10 ideal or, they get references to agencies but they
11 don't specifically define them, so community mental
12 health centers could be a health home.

13 They talk about health home being a team.
14 And again, the team would be comprised of
15 practitioners, but certainly include either a
16 physician, and/or a nurse, and then there is a third
17 parameter, I can't remember exactly what it is, but
18 all four of those need some definition.

19 So, the funny part about this is that the
20 demonstration grants for health homes will be going
21 out, I believe, at the beginning of next year. At the
22 same time, States can actually amend their Medicaid

1 State plans to include health homes. So, it's one of
2 these funny things that CMS is struggling with, which
3 is, how do I design a demonstration project at the
4 same time, figuring out what it's going to look like
5 when the State applies for a health home.

6 Colorado is clear, at least in terms of
7 those health home requests that come in from States
8 but include addictions or include mental health. The
9 State, in our application, is supposed to consult with
10 us. Now, at least that's what it says on paper.

11 We're in the process of working with CMS to
12 define what consultation means, because it can't be
13 just us tapping in the State. It's going to have to
14 be a trifecta, at least, so that we're making sure
15 that we're bringing the good advice back to the State
16 around health homes, as well as Medicaid, CMS hearing
17 what we're saying about health homes, so there's no
18 splitting that goes on when the application comes in.

19 In addition, we're also going to spend some
20 time with CMS around what should a health home look
21 like for individuals with mental illness or co-morbid
22 conditions, or addiction and co-morbid conditions?

1 So, that's where we're at.

2 Flo?

3 Ms. Stein: This would be a Statewide
4 system, you wouldn't expect to have different kinds of
5 health homes in the State, or would you?

6 Mr. O'Brien: We haven't gotten into that
7 discussion stage. I'll tell you right now, January
8 1st seems like such a long ways away, but it will be
9 right on us, you know? Some of the provisions in
10 there, I mean, I think they're going to allow for,
11 certainly, the different conditions and different
12 States to be addressed. I don't think, and I'm hoping
13 they're not going to do what they did on some programs
14 and just say, "You only get one shot at your health
15 home and you're going to have to just say these
16 individuals, and those individuals don't include
17 individuals with addictions." Then you're going to
18 have to wait until we figure out when we're going to
19 allow States to have more than one type of health
20 home.

21 Chairperson Hyde: This is an issue that
22 I've discovered is really -- lacks understanding.

1 There's so many different models, as John said, about
2 health homes, or medical homes, or clinical homes or
3 whatever, and some of the consumer and family groups I
4 met with are very worried about what that means.
5 They're worried that it will be a medical, rather than
6 a recovery-oriented place that they'll be forced to
7 get their care, and then some of the family members
8 literally took the word "home" literally and felt like
9 that, as they were going to have to put their child
10 into a home in order to get care. So, there's
11 misunderstanding, and we're going to have to do some
12 work to get the word out about this issue.

13 I have George and -- did you get your
14 question answered? Okay, George next, and then come
15 back to Ed, then Stephanie and then Mark.

16 Mr. Braunstein: I'm just curious, both from
17 the standpoint of the reform initiative, but also from
18 the standpoint of what you said, Pamela, regarding
19 funding that will come from SAMHSA. To what extent
20 will outcomes be -- will the reimbursement systems or
21 the funding systems begin to incentivize based on
22 outcomes? And I say this because I think that there

1 are times that being someone who puts pieces together
2 and tries to create integrated services at the front
3 line levels. There are times that the payer systems
4 conceptualize what they think will work, but what
5 actually does work is something a little bit
6 different. But then we have to go back and try to
7 talk the payers into paying for what does work instead
8 of insisting on us filling out all of the right forms
9 and checking all of the right boxes to see that we're
10 doing what they think should work.

11 And I -- and some of these ideas, which are
12 great ideas -- I'm just curious as to how it will play
13 out. Because actually, from my understanding,
14 healthcare reform is partially driven by some of the
15 awareness that there are some models that were put
16 together in the field that do show great results.
17 They weren't necessarily conceptualized in the offices
18 of the CMS or anywhere else. So, I am curious about
19 how the system will start moving towards results.

20 Chairperson Hyde: That's a great question,
21 we talk about it in HHS, about paying for better care
22 rather than just more care. And there is some

1 discussion going on about that. John, do you want to
2 comment?

3 Mr. O'Brien: Well, there's a number of work
4 groups that are working specifically on quality and
5 outcome measures first, in order to be able to kind of
6 pave the way for them. How do we use those to think
7 about how to pay for what we want differently? I will
8 say, and I think it's no surprise, kind of the, sort
9 of the same conversations around services where we've
10 got a lot of people having different ideas about
11 services. We've got different ideas about what the
12 right outcomes should be, and so I think one of the
13 first steps is to be clear about what are the two,
14 three, four outcomes or quality indicators that we
15 think are important for mental health and addiction?
16 Because I think it's kind of a little bit all over the
17 map, and I think we're also being asked, frankly, as a
18 field and as SAMHSA kind of what Flo should be in
19 order to say, "All right, these are the quality
20 indicators, now how do we turn that into things that
21 look like pay-for-performance, or pay-for-outcomes?"
22 So, that's the first piece of work that needs to get

1 done.

2 In addition, there's one or two parts in the
3 bill that have demonstration projects around it. One
4 is around paying for episodes of care versus buying
5 widgets, individual services, and how we buy an
6 episode of care that produces good outcomes. And
7 again, even though six weeks seems a long time, it's
8 one of the things that I think is coming, and needs to
9 have some good thought around what they could look
10 like.

11 So, it's both kind of what's the outcome and
12 what's the methodology are going to be really
13 important conversations to have.

14 Chairperson Hyde: We're going to come back
15 to this issue of outcomes and quality when we talk
16 about the outcomes and quality initiative, but it
17 really is true -- everybody is looking at quality
18 initiatives and nobody's agreed to what they should be
19 from here out. So, everybody thinks they're fixing it
20 or they're working on it and we are sort of being
21 asked -- there are people sort of beginning to say to
22 SAMHSA, "You've got to resolve this," or, "You've got

1 to help bring people together to resolve this issue of
2 what is quality and what is the outcome we should be
3 measuring," and expecting -- and you can't hardly do
4 the payment issue until you've got that resolved, as
5 John say.

6 Okay, we've got three more people, and we'll
7 take these comments then we'll take a great. So,
8 we've got Ed, Stephanie, and Mark.

9 Dr. Wang: One of the things I've learned is
10 never ask a two-part question, or give them all at the
11 same time. So, I'll get John to answer them quickly,
12 because there's so much energy in the Council members,
13 here, that I think it's fantastic.

14 I just wanted to go to the second part of
15 the two-part question, which is really -- my passion
16 is, I mentioned earlier about disparities and the use
17 of cultural and linguistic competence tools. I guess
18 what I'm looking at -- and, Administrator Hyde, you
19 also mentioned about your willingness to re-look at
20 discretionary funds and block grants, and so forth.

21 You know, SAMHSA's done some great work,
22 specifically related to cultural/linguistic

1 competence. Great effort has been made both
2 internally, as well as externally, for funding
3 grantors or grantees, to focus in terms of how to do
4 that. I'm just wondering whether SAMHSA can actually
5 continue to be the bridge with other sister agencies
6 at the Federal level as well as HHS agencies to see
7 how can we really do an honest kind of sustainment
8 goal, or replicable or spreadable -- in terms of
9 programming, specifically -- related to the reduction
10 of disparities, especially when I'm looking at part of
11 the Affordable Care Act, for behavioral health
12 specifically. We talk about Medicaid covering
13 preventions, even though we haven't really defined
14 what prevention -- first, secondary or tertiary. I
15 think this is a great opportunity, I think it's a
16 great excitement for SAMHSA to really take the
17 leadership both, I think, internally through its
18 funding as well as externally, working with other
19 partners.

20 And I'm going to actually hold that, because
21 I know that Faye -- and she's very passionate about
22 this for the past two years, I think, will cover that

1 -- and part of that probably tomorrow in her and Tom's
2 presentation. But, I just wanted to add a passionate
3 plea that it is an opportunity now to do something,
4 and do something right.

5 Chairperson Hyde: All right, Stephanie?

6 Dr. LeMelle: Going back to the health home
7 concept, I think -- I know this is somewhat
8 controversial -- but going back to the idea of a
9 hospital-based program, whether it be an outpatient
10 program or an inpatient program for substance abuse
11 and mental health, I think, convincing CMS and the
12 other funders to fund services -- health home services
13 in such a way that you really do have an
14 infrastructure. And the thing that comes to mind is
15 the problem with making, let's say, a community mental
16 health organization your health home. If that
17 community mental health organization does not have a
18 medical infrastructure then -- particularly in rural
19 areas -- the folks who are assigned to that health
20 home are not going to be able to get labs done, x-rays
21 done, really, concrete medical things.

22 And thinking about developing health homes

1 from a hospital base, and using the hospital, really,
2 to provide the infrastructure for what's needed in the
3 community programs, I think, is something that, as I
4 said, has sort of gone round-circle in the last 20, 30
5 years, about moving away from hospitals and into the
6 community, but then really you moving back towards
7 that when you're thinking about how to make an
8 infrastructure work that can cover substance abuse,
9 mental health and medical care.

10 So, I just wanted to make sure that if CMS
11 is involved in these discussions with us that there's
12 a way to put that back on the table.

13 Chairperson Hyde: All right.

14 Marvin, you get the last word before our
15 break.

16 Mr. Alexander: Yeah, and I'm glad I get the
17 last word. Because, actually -- I'm glad you prefaced
18 that with conflicts, because I'm kind of a -- you
19 know, I have some conflict with that. Because I have,
20 in my idea, in the children's services world, we have
21 explored this idea of wrap-around. And a wrap-around
22 plan of service basically brings professionals, multi-

1 agency, interdisciplinary approach to children's
2 services, and it kind of brings these people together
3 and make one plan for a child. And, I think, kind of
4 -- we didn't table the idea of home -- home being a
5 physical location, whether that's the hospital,
6 whether that's the school, or whether -- you mean to
7 tell me I have to put my kid in a home? I mean, I
8 think there's various, you know, perspectives when it
9 comes to physical.

10 But, what I do know is that there is this
11 language about electronic medical record. And I know
12 that there's a lot moving that electronic medical
13 record, there was a commercial -- I think it Phillips,
14 even, who had this commercial where there's doctors in
15 the room, and they kind of went through this guy's
16 life, went through his medical record, they had a
17 doctor here from, you know, Seattle, and a doctor here
18 from, you know, Jonesboro, you know, he told him to
19 quit smoking on this day and that was accessible to
20 his doctor, you know, over in Washington.

21 And, I think with technology, I think we're
22 moving to a place where physical location, I think we

1 transcend physical location. I think what's more
2 important, you said something earlier about teams. And
3 in children's services, we don't have a place, or a
4 wrap-around, I mean, a wrap-around program. We don't
5 have, we said we're community-based, meaning, "We will
6 meet at a school, we will meet at a park, we will meet
7 at the local McDonald's," really coordinate care and
8 come up with a plan for this child, which includes
9 having the primary care physician on the team, which
10 includes having a social worker, whoever that team is
11 working with that family.

12 But, I think there's ways for us to
13 transcend, and don't have to be stuck in a physical
14 location when we talk about health home. And I think
15 that we can bring together -- health home could be a
16 school, especially if we're referring out and we're
17 working as community -- we're working as a community -
18 - to provide services to people.

19 So, maybe -- I wanted to look at the idea of
20 health team. I know we've got home, you want to have
21 a place, but the team of people that's doing the work,
22 what this does look like.

1 Chairperson Hyde: Thanks, Marvin.

2 Okay, this has been a really rich
3 discussion, I appreciate it. Let me remind you, a lot
4 of things you've touched on: prevention, electronic
5 health records, other kinds of things we're going to
6 come back to throughout the couple of days.

7 Just -- at the end of each one of these, I
8 want to remind you that, I know, in this particular
9 area four things that John's working on. One is this
10 whole implementation and reform bill that you've been
11 talking about. The second is, what we're doing about
12 block grants, the third is CMS, Medicaid, Medicare, we
13 talked a lot about that. The one we didn't talk too
14 much about is parity. Both the parity reg and then
15 the parity within the health reform stuff.

16 So, to the extent that any of you think of
17 things later that you'd like to either say more about
18 or talk more about, again, I encourage you to use the
19 leads as the place to go, because I can't always pay
20 attention that I need to. So, use John, copy Toian if
21 you're going to email so we kind of have it all in one
22 place, but keep thinking, keep giving us more input.

1 So, I'm going to break for 15 minutes, we'll
2 stop again and break at 11:30, I want to talk about
3 prevention.

4 [Recess.]

5 Chairperson Hyde: All right, I think we're
6 going to go ahead and short-change any of this. The
7 next one is, we're going to talk about, is our number
8 one priority, which is prevention of substance abuse
9 and mental illness. And I will to point on your fact
10 sheet that's on page four, and on your overheads, or
11 Power Point it is on -- or slide 7. And Fran may have
12 some other things to tell you about.

13 Fran, take it away.

14 PRESENTATION OF FRANCES HARDING, DIRECTOR,
15 SAMHSA'S CENTER FOR SUBSTANCE ABUSE PREVENTION

16 Ms. Harding: Okay, prevention, priority
17 one. It's about time in SAMHSA, outside of SAMHSA,
18 thanks to Administrator Hyde. She saw the wisdom in
19 looking at, we need to begin at the beginning, and
20 that is that if we can prevent these situations from
21 happening, slow down the illnesses from occurring,
22 that we're in better shape to be able to treat.

1 So, for a first priority, which to review,
2 is the priority for, or prevention of substance abuse
3 and mental illness. Our goal, here, is to create
4 prevention, prepare communities for individuals out in
5 schools, work places and communities take action to
6 promote emotional health and prevent and reduce mental
7 illness, substance abuse -- including tobacco -- and
8 suicide across the lifespan. Just a small, attainable
9 goal, we're going to do it all.

10 And the reason why we're focusing on it all,
11 and if it seems like we are, we're doing that
12 purposefully, because this is our time -- everyone in
13 Federal Government and HHS is focusing on prevention,
14 so we're going with the big grab to show people what
15 we can and should be doing.

16 Our issues -- Pam has her Fast Facts in the
17 handouts that you have, some of the issues that we add
18 to that are displayed for you. I'm going to go
19 through the slides rather quickly so we can get into
20 discussion -- some of my favorites are: nearly 5,000
21 deaths are annually attributed to underage drinking,
22 still, in our country -- totally preventable. Tobacco

1 use is the leading cause of death in the United
2 States, particularly, we'll be drawing your attention
3 to the tobacco use of our patients and constituents of
4 mental health and substance abuse that were dying of
5 tobacco-related illnesses before the illnesses that
6 were in our system to treat and prevent -- that's an
7 interesting, but sad, reality.

8 So, we have four goals in this initiative,
9 in the interest of full disclosure. The first goal is
10 to reduce and eliminate substance abuse and mental
11 illness nationally. We're going to go after -- across
12 all systems to prevent -- goal two -- prevent and
13 eliminate underaged drinking throughout the Nation.
14 One of my absolute dedications, to be able to do that.
15 Eliminate tobacco use among youth and young adults and
16 promote cessation of tobacco use among individuals
17 with substance abuse and mental health disorders,
18 which I alluded to a second ago. And, fourth but
19 certainly not last, prevent suicide attempts among our
20 youth, military families and our tribal entities.

21 Some of the NAC members will remember
22 visiting the tribe out in Arizona and learning,

1 firsthand, all of the huge number of young men on our
2 tribal communities that are choosing the route of
3 suicide, which was very heartbreaking to hear that and
4 to hear from the families. So, I'm not going to go at
5 length, you have the goals and the information before
6 you, but I will give you a little bit extra in each
7 goal.

8 The first goal is to reduce and eliminate
9 substance abuse and mental illness nationally. I
10 really didn't want to hear myself -- you have to hear
11 me, I don't. We're going to do this by preventing
12 substance abuse and approved well-being in States,
13 tribal entities and communities across the Nation.
14 And the first way of doing this is through a program
15 called Prevention Prepared Communities. You're going
16 to hear a lot about Prevention Prepared Communities,
17 those of you who love acronyms, it's PPC. I don't, so
18 I call it Prevention Prepared Communities. Prevention
19 Prepared Communities is important -- we could spend
20 all day long talking about this. This is a new
21 initiative that actually came out of the Interagency
22 Work Group of the Office of National Drug Control

1 Policy. We're very excited to be the leaders in this
2 initiative, and our partners -- our first immediate
3 partners -- are the Department of Education, the
4 Department of Justice, ONDCP, of course, NIDA, NIAAA
5 and NIH. And so, we're all working together with
6 SAMHSA's lead to bring communities across the country
7 to focus on substance abuse and mental illness in a
8 prevention initiative.

9 Goal number two, the elimination of
10 underage drinking throughout the Nation. We are
11 working very closely with all of you and our partners
12 and NIAAA especially to work through the prevention of
13 underage drinking work that our Secretary is doing
14 and the work that you are doing.

15 We are raising -- we're actually going to
16 take the action that was in the Surgeon General's
17 report for underage drinking, and make it come alive.
18 Pam had mentioned earlier about the Institute of
19 Medicine's report -- I have copies of this, if you
20 need to weigh down your luggage -- and we can supply
21 this before the end of the day. Inside this report,
22 among other things we will talk about, and there is

1 directives for underage drinking. Much of what came
2 out of this report you're going to see in this
3 initiative.

4 Next is to eliminate tobacco use among youth
5 and young adults, and promote cessation of use of
6 individuals' substance abuse and mental health. These
7 are very new initiatives, so we don't have the actual
8 programming that we can share with you at this point.
9 We're setting ourselves up for 2011. We are going to
10 be working, again, with the Secretary's initiative of
11 tobacco use and reduction, and we're working within
12 both our systems -- our treatment systems and recovery
13 systems of care around focusing both from a youth
14 perspective of tobacco use and the adult perspective.

15 The fourth goal is our suicide goal. Again,
16 we're following the science and the learnings and
17 teachings of our Institute of Medicine's report. We
18 are going to be working on targeting youth. We will
19 be targeting our military families, and we will be
20 working with Kathryn Power on this for her initiative,
21 which you'll hear about tomorrow, with military
22 families, and we're also going to be focusing on our

1 tribal entities, which is rather exciting. We've had
2 a couple of conversations with Sheila Cooper and other
3 members of our tribal councils.

4 We can't do this without partners. Many of
5 the programs that you've seen, and the initiatives
6 you've outlined in our four goals don't really have
7 tremendous funding behind them. We are in the process
8 of aligning our prevention programming to fit our four
9 goals, but we still can't do this without partners.
10 And when I'm speaking about prevention and talking
11 about partnerships, I always say to everyone -- and it
12 rings true today, as well -- you won't find better
13 collaborators anywhere else than the substance abuse
14 and mental health partnership. Anyone that has been
15 trained in prevention is trained, and to learn how to
16 collaborate and how to partner. We do it best, we are
17 employing and empowering our prevention workforce to
18 help our partners across the country -- both on a
19 Federal, a State and a local level -- to show the way
20 in how we need the message of community change, how we
21 understand the messages and the tactics and the skill
22 sets needed to combine programs, combine initiatives

1 to get the ultimate goal. This, too, is outlined in
2 the Institute of Medicine's report.

3 Our Federal partners, and today I've
4 actually -- we have a couple of more that are on the
5 list that we are -- I don't know what you would call
6 it -- I don't want to say we're dragging them here,
7 they're coming willingly. They're asking us
8 questions, the two extra partners that, hopefully, you
9 will see very soon on this list are the Department of
10 HRSA, which we talked about -- Pam talked about a
11 little while ago -- and the DEA. The DEA is an
12 interesting one, because prevention really isn't in
13 the DEA' structure and DNA, so to speak. But they see
14 the value of prevention programming, they see the
15 leadership that is happening and is current. Not that
16 anyone that's been working in substance abuse and
17 mental illness prevention what I call a household
18 name.

19 We now have a workforce issue, that's why we
20 need these partners at the table. [Indiscernible] of
21 substance abuse prevention workforce that has been
22 around for over 30 years -- we have been studying

1 prevention. We have learned from the science, mostly
2 from the researchers from the Society of Prevention
3 Research -- we now have the science of the IOM model
4 which, by the way, is the second version of the
5 Institute of Medicine's report that focused on
6 prevention strategies. We're now working with our
7 mental health partners to show how they, too, can
8 build capacity within the mental health system to join
9 together with the system, and hopefully one day we
10 will have one system for prevention, one system to
11 look at both substance abuse and mental illness and
12 mental health promotion programs across the country.

13 And why? We looked at this because of the
14 data and the facts, but more than that is when you go
15 around and talk to people in our programs across the
16 country, they will tell you that so many of the
17 families, the communities, the individuals, the kids
18 that they work with are seeing both. If you're
19 working in a community center, you're seeing people
20 who are affected by mental illness. You're seeing
21 people who are affected by substance abuse, they're
22 the same people. And to have two separate systems

1 come together and work together, for those of us in
2 the room that worked to bring drugs and alcohol
3 together -- if you remember, there was a day we kept
4 them separate, we thought they were two separate
5 studies, two separate people, two separate programs,
6 and two separate philosophies. When it was brought to
7 us that we were going to combine substance, or combine
8 drugs and alcohol, to make a field of substance abuse,
9 many of us resisted. We kicked, we screamed, because
10 we were unsure, and afraid that there would be winners
11 and losers.

12 The conversations that I have been in to put
13 together a system of prevention that focuses on
14 substance abuse and mental illness, some of those very
15 same reactions, some of those very same questions and
16 fears are coming through again. And so, we're -- I
17 think we're in a very good place to have this
18 conversation. We have the country behind us, we have
19 an Administration that is supporting this. You will
20 here from Director Kerlikowske this afternoon, his
21 priority is prevention.

22 Pam has gotten, I think, every single agency

1 under Health and Human Services speaking prevention.
2 This is our time. Substance abuse is here, to work
3 with you, and we need to hear from you, the Council
4 to, a) who should we be collaborating with that we're
5 not? What are the messages we should be looking at?
6 What are some of the challenges we may not have looked
7 at yet? And, what more can we do to help bring a
8 system to bear to bring the two skills sets, the
9 funding together to be able to help the young people,
10 the communities, the families across our country.

11 So, I did it fast, Pam.

12 Chairperson Hyde: Thanks, Fran, that's
13 terrific.

14 Let me add just a couple of quick things in
15 emphasis, then open it to you all.

16 On the underaged drinking and alcohol issue,
17 we've been working -- actually, I think Fran mentioned
18 this -- with NIAAA, with CDC, with NIDA -- even though
19 it's about alcohol issues -- and with HRSA and with
20 the Assistant Secretary of Public Health -- all of
21 whom are interested in this. And we not only look at
22 underaged drinking, prevention, services or

1 activities, but we want to look at policy work.

2 There's actually some evidence, now, about
3 what kind of policies reduce the use of alcohol among
4 underaged folks, including things like taxes, which is
5 not a very fun thing to talk about, but it is a policy
6 that tends to work. And we look at policies and happy
7 hour policies and all kinds of things that have an
8 impact.

9 The other thing I just want to highlight is
10 I think I personally -- and Fran, I'm sorry to throw
11 this at you, here, but I'm personally not sure, yet,
12 whether a prescription drug abuse should be just under
13 our general drug abuse prevention because it's such a
14 growing issue. And I've heard it everywhere I've
15 gone, from travel groups, to community groups, to
16 providers to everything else. So, this issue -- and I
17 think Gil Kerlikowske is interested in this issue, as
18 well, this growing issue of prescription drug abuse.
19 I don't know if we're going to pull that out as a
20 separate thing, or keep it tucked up under the other
21 one, but just so you know, that's an issue of concern
22 for us, as well.

1 So, the floor is open to you. We have about
2 a half an hour, let's see what you have to say.

3 Judy?

4 Ms. Cushing: Judy Cushing. As you're
5 looking at the underaged drinking issue, I would
6 encourage you to refer to the Institute of Medicine's
7 report called Collective Responsibility to Prevent
8 Underaged Drinking, that was produced by a panel in
9 2003. It outlines some of those very strategies, Pam,
10 you're talking about: registration, early education,
11 lots of policies at the State level that can be
12 implemented that really show effectiveness around
13 reducing underaged drinking, and new and emerging
14 policy in the underaged drinking arena is outlet
15 density and saturation. And there's a lot more
16 research going on about that now. But that report is
17 actually how the Interagency Workgroup on Underaged
18 Drinking ended up being formed, and so it might be
19 helpful as you're looking to design things.

20 Chairperson Hyde: Yes, thanks. We're
21 actually where we need to reenergize that group. It's
22 been a little dormant for awhile, and the Secretary

1 previously had, I think, tasked SAMHSA with leading
2 that group. And so, we've mentioned it, and we're
3 trying to think about how to reenergize it. So,
4 that's good information.

5 Ms. Cushing: Also, as you're looking at
6 underaged drinking, I hope -- I'm assuming that
7 college drinking is included in the initiative? It is
8 a very significant factor, and it is one that college
9 president's are really struggling with, and one that
10 our Federal Government can help lead in the policy
11 arena.

12 One last question is around the block grant.
13 Your discussion earlier, about looking at the block
14 grant, the way it's structured currently. Wondering -
15 - I would assume, maybe, some discussions have
16 occurred, but as we're listening to Fran outline this
17 prevention and mental health, substance abuse
18 initiative, if there's consideration -- serious
19 consideration -- of looking at the block grants and
20 the percentage that presently goes to prevention or
21 doesn't go to prevention, how that might look, and how
22 differently, and how it might be structured.

1 Chairperson Hyde: I think I'll let Fran
2 comment on the college drinking. I know NIAAA is
3 interested in this issue. If you want to comment
4 about that, then we'll go back to the other issue.

5 Ms. Cushing: The college population is not
6 only going to be addressed in the underaged drinking,
7 it's also going to be address in the Prevention
8 Prepared Communities that -- all of these things are
9 in the beginning stages, no necessarily underaged
10 drinking. And that actually is coming out of the
11 National Prevention Network through NASADAD who, many
12 of our States have asked us to seriously take a look
13 at the underaged drinking on the college campus. And
14 when we're talking policy, policy was very effective
15 on college campuses with the supporting programs that
16 also transcends into what your other issue is -- was.
17 The high-density, I think, you were talking about, and
18 location. That's another policy that college campuses
19 have been working with for a number of years that
20 we're hopefully going to be able to help them with, as
21 well, if we don't restrict availability and force the
22 laws and regulations and actually have high policies

1 to look -- we'll never get to that normative change on
2 the college campuses, as well.

3 So, that one kind of combines and crosses
4 over, if you will.

5 Chairperson Hyde: With regard to the
6 prevention block grant, I think it is safe to say
7 that, given that this is our top priority, we're
8 looking at, what does that mean, for the prevention
9 set-aside within the substance abuse, prevention, and
10 treatment block grant and also within the mental
11 health block grant.

12 So, we are looking at that. I think rather
13 than me telling you what we're going to do, because
14 that's not completely settled, I think I'll put that
15 back to you to say what is it that you would recommend
16 that we do, or what do you advise that we look at as
17 we're trying to figure that out? So, you don't have
18 to answer that now, but your input would be of use in
19 that regard.

20 Marvin?

21 Mr. Alexander: I just want to comment about
22 how excited I am that Fran Harding is leading the

1 prevention work.

2 Chairperson Hyde: You have a fan, Fran.

3 [Laughter.]

4 Mr. Alexander: She's definitely someone
5 excited about prevention.

6 You also made a comment about prescription
7 drug use, because I think that's probably more used
8 than elicit drugs. Prescriptions in young people that
9 I work with just frequent the conversations that's had
10 about being able to go in and, I guess, fake signals
11 to get the drugs that they want to use, including
12 psychotropic drugs. I think there's also a piece,
13 when we talk about prevention of education, educating
14 providers about things to look for and really
15 exploring, especially culturally, exploring the kind
16 of symptoms in more depth, instead of just writing the
17 script. That's -- usually, that's the easy thing to
18 do.

19 Also, when we think about prevention, I just
20 wanted to throw in that cultural competence piece that
21 we're creating: prevention, what's the term? Is it
22 PPC? Recurring PPCs that are culturally sensitive in

1 understanding and that they're also address, those
2 other social determinants to use -- whether it's
3 poverty, or depression, or the other underlying deals.
4 They're doing the work.

5 Chairperson Hyde: That's a great comment.
6 The IOM report that Fran talked about, I have been
7 really impressed at some of the -- learning some more
8 about that report. And they do lay out the risk and
9 resiliency factors and the factors do fall into
10 everything from genetics, predispositions, whatever
11 you want to call it, to psychosocial to social. And
12 poverty is clearly one of those social issues.

13 Mr. Alexander: That's why I always think I
14 -- you know, you say taxes, well, these people are
15 poor anyway, they're still finding a way to use the
16 drugs.

17 Chairperson Hyde: Yeah, that's true, that's
18 true. It's just increasing the cost of cigarettes
19 reduces the use of cigarettes among youth, and
20 reducing -- I mean, increasing the cost of alcohol
21 reduces its use among youth. So, that's a tough call,
22 but that is one policy thing that seems to have some

1 evidence that if you do it, it reduces young people's
2 use. I don't know what we do about prescription drugs
3 and increasing the cost of those. We'll have to get
4 John back for that issue.

5 Arturo, you're next.

6 Mr. Gonzales: A couple of questions: when
7 you talk about collaborations among these groups, what
8 does collaboration mean? Does that mean they're
9 bringing money to the table, in order to fund these
10 programs, or just getting together and strategizing?
11 Are they bringing money -- putting money into the pot,
12 or what?

13 Ms. Harding: That's a good question. I
14 wasn't sure if Pam was jumping in, I saw her light on,
15 I wasn't sure. That's a very good question.

16 In the past, I would say that collaboration
17 -- especially around substance abuse prevention
18 programming will win out in the communities and we
19 brought people together to work. I think it was, they
20 came so that they would be a part of the solution in a
21 particular community level, and in the Federal
22 Government. There wasn't this list that was growing

1 as the day gets long.

2 We're not talking, right now, about sharing
3 of money, but what we're talking about is "braided
4 funding."

5 "Braided funding" is the new terminology here in the
6 Federal Government, and let me explain to you what
7 that is, because it's going to make a difference in
8 how we're moving forward with these initiatives.

9 Braided funding essentially means that I'm
10 not asking you to do anything different than you're
11 doing right now, but what I'm asking you to do is to
12 do this in a different context that we're all working
13 together, so that we're going to start integrating the
14 services where it makes sense.

15 And you're going to come with your money,
16 and I'm coming with my money, and we're going to
17 interrelate the money, but you're still funding for
18 the original services you bring to the table, you've
19 lost nothing and you've gained what the other people
20 at the table are bringing.

21 So, are they coming with money? We'll wait
22 and see. They are coming with the programming, which

1 translates into dollars of what they're doing and the
2 programming of what we're doing, specifically for
3 mental health and substance abuse, which is the
4 closest for us to look at. Our programs are now
5 going to be working together under one umbrella,
6 because we've noticed that the programs, the
7 individuals and the families in the communities
8 that are dealing with one problem of substance
9 abuse are most likely dealing with the other
10 problem of mental illness.

11 So, we're coming together with the two
12 programmings and we're going to be working side-
13 by-side for the first year. Slowly, we'll be
14 integrating them together. So, I'm not -- a dime
15 in the substance abuse dollar at the beginning
16 isn't going to be shifted over in substance abuse.
17 Professionals aren't going to be asked to
18 immediately do mental health programs, mental
19 health programs are not going to be immediately
20 asked to do substance abuse programs. But what we
21 are asking, and what we are leading is for the two
22 programs to come together and to work together --

1 with funding, with experience, with skill sets,
2 which will make a stronger system. Does that
3 help?

4 Mr. Gonzales: Well, yes and no. I guess
5 the no part is, to my Spanish-speaking mind, I don't
6 understand the culture conceptually. Sooner or later
7 it's like, to be effective, it's like you live
8 together or you get married. You've got to put
9 something on the table, otherwise you haven't changed.

10 Chairperson Hyde: There's some people who
11 are not allowed to get married by Congress.

12 [Laughter.]

13 Chairperson Hyde: I don't totally mean to
14 be funny about that, there are some ways in which our
15 money, by Congress, is not allowed to get married.

16 So, what we're trying to do with the braided
17 funding is do things like in one RFA. You could apply
18 for three or four programs, instead of having to apply
19 for this one in May, and that one in June, and this
20 one in July and that one in August, and you don't know
21 if you're going to get all of those programs.

22 So, literally, we've done it a couple of

1 times, now, within SAMHSA and at least one time with
2 another Department, where their money and our money,
3 you can apply for it at the same time, you get the
4 answer at the same time, you get both funding.

5 So, that is what we mean by "braiding," more
6 practically.

7 Mr. Gonzales: Maybe, as long as there is
8 that oversight.

9 The other thing I wanted to ask is about
10 youth. What about the baby boomers? People like
11 myself, aging, you know, that as we retire and start
12 drinking and all kinds of stuff like that, depressed,
13 are you looking those partners' programs?

14 Ms. Harding: Our programs are focused on
15 the life span, actually. We do a lot of talking about
16 this in our workgroups, here, in SAMHSA about the
17 question between, are we talking zero to eight, are we
18 talking zero to 24? Are we speaking the lifespan?
19 What are we talking about with each program? We're
20 finding out -- and the more we talk with the States --
21 that it's all of the above. And it will also be part
22 of the braided concept of who is working with whom at

1 the time. Our older adult population -- we have a
2 very good partnership with the Department of Aging.
3 Here at SAMHSA we have a smaller, focused program for
4 aging. But we have, in treatment, we have in mental
5 health, and we have in substance abuse, focusing on
6 it. I often tell, if I were doing my usual shtick,
7 here, as I get older, the importance of the baby
8 boomer generation gets more important to me, so I am
9 ensuring that that program remains intact and gets
10 stronger.

11 But, on a serious note, we are. And that is
12 so important, because our older adults, you know, we
13 look the other way with them. Because, "Oh, they're
14 80, let them do what they want to do," or, "You know,
15 they've lived a long life," but all they want is the
16 same information in their later life as they want in
17 their life right now.

18 So it is almost -- we also talk about the
19 responsibility of parents, when we talk about parents
20 and young people with prescription drugs, alcohol and
21 substance abuse, and now the signs and symptoms of
22 mental illness. The signs and symptoms of suicide,

1 which we're now working with our parents to say, some
2 of you are in the sandwich generation, you're dealing
3 with your young people, 16, 17, 18, 19. You're also
4 dealing with your parents.

5 So, many of the messages, though crafted
6 differently and presented differently, the same type
7 of teaching, same type of awareness raising, and many
8 times, same issues. It's an interesting, interesting
9 thing.

10 Chairperson Hyde: Okay, I've got lots of
11 people on the list, here. George, then Don, Judy --

12 Mr. Braunstein: I didn't have my hand up.

13 Chairperson Hyde: All right.

14 Don?

15 Dr. Rosen: Thanks so much for your
16 presentation. I'm intrigued by the opportunities in
17 prevention, and particularly with the braided concept.
18 I want to dovetail a little bit on what Arturo said.
19 It's almost easier to talk about braided financing
20 than it is about braided authority. And I'm curious
21 about the idea -- you said these things would be
22 coming together under one umbrella, and I thought,

1 "Whose umbrella is that?"

2 And if you could speak a little bit about
3 your concepts, about how things get braided in terms
4 of authority.

5 Ms. Harding: I have two answers for that --
6 one, depending on the level -- actually three. One,
7 depending upon the level you're talking about, because
8 we're continuously going back and forth from Federal,
9 State and local. If you're at the local level, the
10 umbrella is the convener of the community groups,
11 whichever community coalition group, council, whatever
12 people call the coalitions that are at hand that will
13 -- the convener of that will be the convener of all of
14 the braiding and the services.

15 At the State level, it will depend upon a
16 multiple, because we're looking to fund, for
17 prevention, SAMHSA and for funding for all States to
18 have a State plan for their prevention services for
19 substance abuse and mental illness. So, the convener
20 will be whomever comes at that process, as well, with
21 the date-driven process.

22 For the Federal level, it depends who you're

1 talking about, when, if we're talking about substance
2 abuse and mental illness, moving this into the larger
3 system, sometimes we're the convener, sometimes the
4 Assistant Secretary for Health will be the conveners.
5 I think that that convening will shift for the
6 Prevention Prepared Community, SAMHSA is the
7 community, SAMHSA will be the leader in bringing
8 education services, justice services, and all of our
9 research partners to the table to move forward
10 together, both in individual, and a braided way, if
11 that makes sense.

12 Ms. Cushing: A question about goal four,
13 and your preventing suicide and attempted suicide in
14 military families and members of tribal entities. I
15 encourage you to go to your lifeline system here at
16 SAMHSA, the National Suicide Network, and look at the
17 data that the Centers have gathered over the last year
18 on the populations and ages of the groups of people
19 who are calling Lifeline as a lifeline to prevent
20 suicide.

21 When the economy started to roll downhill in
22 late 2008, those of us who run those Centers really

1 began to see an uptick in suicide calls. Some of us
2 have seen tripling in suicide calls over the last
3 year. A majority of those calls are coming from
4 Americans who are out of work, who are desperate.
5 They've lost their homes and their jobs, et cetera.
6 Some are coming from -- and a growing number -- from
7 military. But I hope you won't leave that mainstream
8 citizen out who really, really feels desperate, at the
9 end of their rope.

10 Ms. Harding: Here's the detail of
11 information about the initiatives themselves.

12 The initiatives talk about umbrellas -- the
13 initiatives themselves are the umbrella for SAMHSA to
14 be focused, to have somebody take responsibility, to
15 pull the agenda together and move forces forward.
16 With substance abuse and mental illness prevention,
17 our partners within SAMHSA is the Center for Mental
18 Health Services. So, the Center for Mental Health
19 Services will continue to do the Lifeline, that -- the
20 programming that they are doing with suicide, with the
21 military families, with all of the things we're
22 talking about, but they're not doing it in partnership

1 with us.

2 So, what we're going to do for you -- this
3 is a perfect example -- while mental health continues,
4 the people you're working with on a regular basis
5 continue to work with you. You will also have the
6 richness of, now, the substance abuse Center, to be
7 working with them, in partnership, so you will get
8 double. So, hopefully we can listen and hear from
9 you, where we should be bringing this, and how can the
10 lifeline help with substance abuse issues or vice
11 versa, or shouldn't it? Should they stay separate,
12 but move towards the same direction?

13 I hear you loud and clearly. I know those
14 lifelines, for you, are important and I know mental
15 health knows they're important.

16 Chairperson Hyde: Okay, Stephanie's next.

17 Dr. LeMelle: Don asked part of my question,
18 which was who would have control, and I see you have
19 these three layers. But I think that -- I think when
20 we're thinking about collaboration, it's the
21 cohabitation, not whether you're married, but whether
22 you're living together that, really, I think on the

1 front line makes a difference. And if there was a way
2 to link that cohabitation to the funding -- even if
3 it's from different funding streams -- if a
4 requirement is that you have to cohabit with these
5 other facilities, that might be a way to sort of bring
6 the resources to one spot.

7 The only other comment I wanted to make is
8 that I think that the prescription drug issue is a
9 separate issue, and I think it needs to be, I mean, it
10 falls under the same umbrella. But, I do think that
11 the approach to prevention and treatment is very
12 different than substance abuse and alcohol abuse.

13 Ms. Harding: So, are you saying that -- let
14 me make sure I'm hearing you correctly -- are you
15 saying that the substance, the prescription drug issue
16 should have it's -- a separate goal within this
17 initiative, and we should be partnering with treatment
18 so that we're looking at all sides of the prescription
19 drug problem, the prevention side and the treatment
20 side, as well? Is that what I'm hearing?

21 Dr. LeMelle: I think so. I'm not sure the
22 goal is different, I think the goal is probably the

1 same, but the objectives and how you go about
2 attaining that goal are a little bit different with
3 prescription drugs.

4 Ms. Harding: Okay. We failed to mention,
5 but we hope that by the end of tomorrow, it will
6 become obvious that all of these initiatives we're
7 working together across initiatives, and you're going
8 to see a little prevention, hopefully, and most -- if
9 not all -- of the initiatives, just as I'm working
10 with Dr. Clark, especially on the workforce issue,
11 around how are we bringing these two -- it appears to
12 be on even workforces together or bringing the talents
13 of both sides, as well.

14 Prescription drugs, I have gotten that
15 message, and the collaboration piece, the cohabitation
16 piece you're talking about, we're hoping that the
17 Prevention Prepared Community Program will be an
18 example of this and quickly, without describing it too
19 much, SAMHSA has the lead in the Prevention Prepared
20 Communities. We have two major partners from the
21 other Federal agencies, Department of Justice,
22 Department of Education. There is no money for

1 SAMHSA, Department of Education, Department of
2 Justice. The money is for the States, and
3 communities, and tribes.

4 So, it's the "what's in it for me?" factor
5 and going back to your question, Arturo, is, "So, why
6 would I come together and work with you?" and that is
7 the biggest question. And what we're hoping to show
8 by bringing these partners together, because what's in
9 it for them, it's the cohabitation outcome, which is,
10 we know that these three Federal agencies are working
11 on the same issues. We want to bring all their
12 talents and their programming together under one
13 guidance, one umbrella, one leadership -- that is
14 what's in it for them, because the winners are the
15 States, the communities, the individuals, and the
16 country.

17 Chairperson Hyde: Okay, great.

18 Cynthia's next, then Flo.

19 Ms. Wainscott: Cynthia Wainscott.

20 I think you're very, very smart to have
21 smart people, like Fran and others. I'm curious,
22 everybody's going to be on par to what's going to make

1 it work. It's accountability, it's a very good
2 management, I think. And I'm real happy to hear that
3 the substance abuse prevention specialist skills are
4 going to be available to the mental health community.

5 I think the bigger problem is going to be
6 getting the mental health program directors engaged.
7 They're overwhelmed with sick people, they're
8 underresourced. The work with a politically driven
9 budget that gives them no incentives for long-term
10 savings.

11 I think one strategy that might be
12 successful would be to recruit, probably, through
13 NASMHPD, one of them as a champion. Maybe NASMHPD
14 itself could become a champion of this. It will not
15 be an easy sell, because they don't have time for
16 this, they don't have incentives for it, it is not
17 what they've been trained to do, and some of them
18 disbelieve that mental health prevention is possible.

19 So, I think another strategy will be to do
20 some real education of those policy leaders, and
21 perhaps assist some of the prevention leaders in the
22 States to educate the legislative policy leaders that

1 are going to appropriate, or not appropriate, money
2 for this. So, there's going to have to be real
3 learning in that IOM prevention report. It has to be
4 the Bible. How you get it out, I'm not sure, but
5 there are a lot of smart people who have been doing
6 this kind of education and advocacy for years who
7 would be happy to work with you. The block grant --
8 nothing saying lovin' like something from oven. And
9 nothing says, "This is important," like money from the
10 Feds.

11 So, if you get some mental health prevention
12 money going down to the States, it's going to be a,
13 "Hello, we need to be doing this." And it's going to
14 create the incentive to learn, and so I'm more than
15 supportive of that.

16 When I think about the mechanics of a plan
17 for mental health prevention, how would you do that,
18 I'm going to be doing some thinking about it, and I'll
19 be in touch with Fran after I've talked with some
20 folks from home. Because when we could do it, is
21 attach it to require that a joint plan come up. And I
22 think in some States that would work, and then other

1 States it might not. But, I'll do some thinking and
2 talking.

3 The last point is, places to collaborate. I
4 also believe the prescription drug issue needs -- we
5 only tend to think of it for youth. We think about
6 schools, and training, people my age -- it's a huge
7 problem. It's a huge problem, and people my age
8 understand it, because they've got grandkids they're
9 worried about and they've got a neighbor they're
10 worried about. So, there's some collaboration
11 opportunities there, and I can't think right now how
12 to do it, but the business community is a potential
13 ally in all of this, because they increasingly get it.

14 I'm very excited about something that North
15 American is doing nationally. We go into these
16 meetings thinking we're going to have to convince
17 business people they need to be making mental health
18 treatment available, and working on prevention and
19 promotion activities -- they're ahead of us, at times.
20 So, they're an ally, but I don't know how to quite go
21 to that. But, if you only do it with the State mental
22 health authorities and State substance abuse

1 authorities, we're not getting the best bang for the
2 buck.

3 Chairperson Hyde: Two quick comments about
4 that, Cynthia. This is good feedback, actually. We
5 didn't probably talk as much about it as we should
6 have, but mental health promotion for children, I
7 think, is a way we can engage the mental health
8 community a little bit more and we want to try and
9 talk about that more in this context.

10 We had a really great program at CMHS,
11 managed the leadership of putting on this last week
12 about children's mental health promotion and IOM
13 reported very clearly about that. And I think -- so
14 we're going to be trying to do more about that in this
15 prevention, promotion initiative.

16 And then on the business community, you're
17 right. They came, actually, to our meeting that we
18 had about health information technology and their
19 issue was, really, that they need to be ahead of this
20 game, and they're already thinking about it, and so
21 raise that point again when we get to the Jobs and the
22 Economy, because one point under the jobs and the

1 economy is helping businesses understand their roles
2 in both prevention and treatment. So, bring that back
3 again.

4 Did you want to say any more about that
5 Fran?

6 Ms. Harding: No, I was just going to say,
7 one of the things -- I'm trying to get through this
8 quickly -- I didn't mention is, we're not starting
9 from scratch. We're starting using the proven
10 strategic prevention framework model which does
11 encourage communities to look at businesses and other
12 parts of the community. I kind of flipped over that.
13 And we work with something so much, but it is going to
14 be a prominent -- it has been so successful that we're
15 not making SPFs across the country, but we're going to
16 use the strategic logic, 5-step logic model, that will
17 help States be able to plan, and that is what I'm
18 referring to in the plan.

19 But, Cynthia, I think your ideas are spot-
20 on, and I will hold you for coming back to us with
21 more informing.

22 Ms. Wainscott: Engaging the business

1 community, my motto -- and I tell this story sometimes
2 -- Judy was about going up to Hood River and having --
3 and you'll miss this, Pam, the local tavern owner came
4 as part of the local business coalition, and talked
5 about how he is working on substance abuse prevention.
6 Wow, that's engagement.

7 Chairperson Hyde: Okay, Flo, you're next,
8 then Anna wants to say something, then we're going to
9 wrap up for lunch.

10 Ms. Stein: Thanks.

11 And thanks, Fran, for your leadership. What
12 I want to commend you for is focusing in on the early
13 initiation tobacco and suicide and narrowing down the
14 focus a little bit. Because what I think you're going
15 to need to be working on in the future is some models
16 -- some integrated models -- that allow us to get to
17 work on health outcomes for the whole family. Because
18 if we're going to move in -- move prevention into
19 health reform, it's got to be about things we do now
20 that have ultimate health outcomes for people, and
21 these three are really important parts of that, and
22 that I think we really need some developmental work.

1 Chairperson Hyde: Great, thanks.

2 And we are actually, to comment, we really
3 are trying -- I hope you can see in this, even though
4 this is a broad agenda, we're really trying to get
5 down and say, "What are the three or four things we
6 really want to focus on?" So, I appreciate that
7 comment, because people sometimes want us to do more
8 and more and more. We can only do so much. It's
9 helpful to make a dent.

10 Anna, did you want to make a comment? Then
11 we'll wrap up, here.

12 Ms. Marsh: I just wanted to say something
13 about the suicide prevention in response to Judy's
14 comments. To agree, first of all, about the
15 usefulness of the data from our suicide lifeline
16 calls. In fact, just yesterday we were making
17 presentations to our OMB examiner, and presented some
18 of the data, including the increase of calls, the
19 monthly calls this year compared to a year ago. It's
20 difficult, though, to distinguish whether that
21 increase in the calls is an actual -- reflect an
22 actual increased need, or if it is just an increased

1 demand. That is, people are knowing the suicide
2 lifeline is there, so the calls are increasing.

3 However, I wanted to mention, in our
4 collaboration with OAS, the survey now has an expanded
5 module on mental health and suicide in their data that
6 were released last September from the 2008 survey,
7 showed that for the first time, we have data --
8 national data -- now on the number of self-reported
9 suicide attempts. So, according to the data, .5
10 percent of the adults age 18 and older reported having
11 attempted suicide in the past year, which is over --
12 which is a lot of people. With the combination of the
13 data and the suicide lifeline data, we're able to make
14 a very good case.

15 I also want to harken back to what you said
16 about the campus problem. As you probably know, we
17 have a campus program for suicide prevention, so it is
18 useful to think about various, multiple problems
19 occurring on campuses so we can collaborate to
20 prevent.

21 Chairperson Hyde: Did you want to say
22 something about that, Judy? I do want to get us to

1 lunch.

2 Ms. Harding: You could help a lot of us
3 around the country with that kind of funding stream,
4 like the grant -- not in every State do the entities
5 work together. For instance, they will be siloed, so
6 that funding goes to one department who doesn't
7 necessarily work with the mental health department or
8 the alcohol and drug department or local entities.
9 And anything you can do to kind of push and facilitate
10 much better cooperation there, it would be greatly
11 appreciated, because that funding was intended to --
12 it is doing some really great things, but I've had
13 people call, say, "Why aren't you involved in this?"
14 And I know my colleagues in some other States have
15 experienced the same thing. So, SAMHSA can help,
16 almost, force that operation.

17 Chairperson Hyde: Okay, great.

18 I did want to say, both to intrigue Kate a
19 little bit, and to intrigue you all for Pete coming
20 up, one of the things we toyed with was that, you
21 heard in John's presentation that there's certain
22 prevention services that have some evidence behind

1 them that are going to be required in essential
2 benefit packages and other kinds of things. But, one
3 of the things we kind of came up with, this theory
4 about was, maybe, trying to get at some prevention
5 billing codes that go beyond SBIRT, because that is
6 prevention, but it's also intervention, it's a little
7 beyond prevention.

8 So, we're trying to think about what would
9 that mean, how would you do billing codes? Because,
10 obviously, we tried to do universal or a population-
11 based prevention, and -- but then what happens when
12 the psychiatrist, or the doc, or whoever it is talks
13 to the kid of the depressed mother who was in? You
14 could argue that that's prevention, intervention, and
15 we don't have any way to capture it.

16 So, even if they don't pay for it, being
17 able to capture it so you get the value of the
18 service, at least, at some point. So, we sort of
19 toyed with that, whether or not that is worth taking
20 on. So, you can think about that over lunch and let
21 us know.

22 So, this is great -- another rich

1 conversation. We're going to start up again right at
2 -- we're asking Terry Cross if he has an email before
3 we wrap up, let us figure that out. No? Okay. So,
4 Terry, I'm sorry this has been hard for you, but we
5 will keep trying to keep you on.

6 We will start right at 1:15, so please try
7 to be back about 1:10 or so, so we can get started on
8 time. We don't want to get behind, because every one
9 of these topics deserve the full 45 minutes, so thanks
10 a lot.

11 Thanks, Fran.

12 [Recessed for lunch at 12:20 p.m.]

13 [Reconvened at 1:15 p.m.]

14 Chairperson Hyde: We're going to get
15 started.

16 This particular initiative -- we have all
17 kinds of quality initiatives, and on your sheet of
18 paper, your fact sheet, it is number 9 and it's on
19 page 10. And on the overheads, Power Point, it is on
20 slide 41, okay?

21 So, those are the things and then obviously,
22 before we get started, I want to introduce -- I

1 actually said his name earlier today but he was
2 downtown being fingerprinted -- Steven Rendazzo, who I
3 told you was starting yesterday. Steven is the one
4 who's going to be working partly with John on health
5 reform issues, and partly on social media and he's
6 worked with me for several years and is interested in
7 human services, communications, and so he has a little
8 bit of everything.

9 So, we've worked him hard and put him up
10 wet. Anyway, welcome Steven.

11 Okay, Pete, are you ready to go?

12 STATEMENT OF PETER DELANY, Ph.D., LCSW-C,
13 DIRECTOR SAMHSA'S OFFICE OF APPLIED STUDIES

14 Dr. Delany: So, this is also a very
15 focused, kind of, small initiative to wrap our hands
16 around: How do we measure all initiatives? The goal
17 of this is to move -- in about 2006, we moved to a
18 data strategy and we were to move to the next
19 generation of data strategy. When you think about the
20 integrated plan, that really helps inform policy and
21 measures the program impact on results and improved
22 outcomes and improved quality of those outcomes for

1 individuals with families and communities they live
2 in.

3 So, there's several things, and I want to
4 kind of break this down for you. So, to look at
5 creating a greater balance and collection of analysis
6 and dissemination of substance abuse to create some
7 common access points for the data and other
8 information to meet stakeholder needs to enhance
9 capacity to provide real-time data to staff and
10 constituents and move into the next generation of
11 outcome measures that are consistent with healthcare
12 reform and also consistent with SAMHSA's strategic
13 initiatives and improve the quality of our evaluation
14 and our knowledge development, and then to make the
15 performance data easily available to everybody.

16 So, pulling this back a little bit, I want
17 to think about this in terms of three major areas:
18 one is the infrastructure area, second is measurement
19 quality, third is evaluation and information
20 development, and finally, the access to dissemination
21 of data, and we'll get into a dialogue about those
22 steps.

1 So, when we think about infrastructure, a
2 few of the things we're looking to do is to create
3 some common data platforms and common data points
4 within SAMHSA so we have some consistency across our
5 programs, but also that this data platform recognizes
6 the specific and unique differences of each of the
7 Centers.

8 We're looking at -- to move further into
9 integrating some of our substance abuse and mental
10 health data system, for example, we're looking at how
11 to approach facilities data systems. As was pointed
12 out earlier, we're working collaboratively to be, not
13 just a substance abuse treatment and prevention data
14 system, but also a mental health data system.

15 We're also looking to expand the analytic
16 support within SAMHSA to build not just a contract but
17 now a greater flexibility so we could do new analytic
18 work.

19 And, finally, we're looking at expanding the
20 data systems we have available, and we're very excited
21 that in the next fiscal year, we'll be launching the
22 development of a new community-based system that

1 focuses on the needs of communities in a way that
2 allows them to vote control, and push in data that
3 would help them make decisions, as well as to expand
4 what we're doing within the facilities, to watch
5 what's happening.

6 As healthcare reform rolls in, I think the
7 reality we all know is that specialty treatment
8 programs are not going away, but they're going to
9 change, and we need to know what's happening when we
10 get there.

11 So, in terms of the second area, measurement
12 and quality, well, we're looking at a number of areas.
13 One of them is a theme that I've been pushing and I
14 think I'm really excited over is grabbing onto is, we
15 really need to rethink what's meaningful and what's
16 useful -- not continue to expand our data, but look at
17 what we have now. Is there stuff that should be kind
18 of -- happen to go away? We're working with Daryl's
19 shop and some of my colleagues, they've been really
20 taking the leading on reducing some of the GPRA
21 measures, and focusing on how that helps make us
22 really be able to demonstrate do our programs work,

1 and how well, and we'll be continuing to define GPRA
2 and how it's used within SAMHSA. That's the
3 Government Performance and Results Act, those are the
4 measures that we've used.

5 At some point we'll stop talking in acronyms
6 -- it may not happen for another year, but we do have
7 a test at the end of the day. So, the Government
8 Performance and Results Act is one of the ways within
9 the budget line where we put in the budget to
10 demonstrate, are we moving forward in the right
11 direction with our programs, and also to look at
12 outcome measures, thinking about, again, do we have in
13 place, are they meaningful, are they useful, should we
14 move to the next generation? Do we need to look at
15 where we're using -- the whole idea is to begin
16 thinking about, here, is the national level, again,
17 and down to the program level, and the client level --
18 that they should, in between the community, States, so
19 there should be some cascading up and down, so it
20 makes sense. It's not like we collect all of this
21 data over here at the national, and then we use
22 something for here, and then here's the outcome data.

1 We're trying to move away from the silo end of the
2 data, as well as the silo end of the programs. That's
3 really the bottom line.

4 And, within that, too, I think, the other
5 idea that comes up -- there's a couple of things you
6 will see on your slides about data outcomes. One of
7 them is thinking through and we'll really be asking
8 for your feedback, conceptualizing what we mean by
9 recovery. We've talked about recovery, and I've been
10 in the treatment field for over 30 years this year,
11 and I have had a lot.

12 Ms. Wainscott: I thought you meant 30 years
13 this year, during this year.

14 [Laughter.]

15 Dr. Delany: Okay, I'm going to get you
16 later.

17 [Laughter.]

18 Dr. Delany: Anyway, now I'm totally off.

19 But, thinking about, how do we conceptualize
20 recovery, both for mental health and for substance
21 abuse. There's some unique things, some common ideas.
22 And then if we're going to conceptualize it, then how

1 are we going to measure so we can say, as a field,
2 "Look, we're moving forward in the programs we're
3 doing, we're actually leading towards recovery."
4 Nothing helps a politician like a piece of data that
5 says, "Okay, that makes sense."

6 And I've also learned that they don't like
7 lots of charts, they like one chart. In terms of
8 evaluation, we're moving towards having and enhancing
9 our standards or creating some common and basic
10 standards for developing evaluations around our
11 program, and this is, again, a question that I talk
12 about -- what makes sense to evaluate? Is it the big
13 programs, the little programs, the target programs?
14 What are the kind of criteria we need to set for when
15 we're going to go ahead and put something in place to
16 evaluate, and not everything should be evaluated.

17 Related to that is information development.
18 We need to be, because I come out, my history is out
19 of NIH at NIDA and NIAAAA, I ran health services
20 research programs -- they're not moving into a
21 knowledge in the way we think about it, which is more
22 practice related, they're really looking at kind of

1 very focused things, like behavioral health testing,
2 and when I left NIDA, we were testing cognitive
3 behavioral health, cognitive behavioral therapy on the
4 15th version of some population that had been tested
5 before. And as you know, at NIDA, we like to rule out
6 somebody that has a co-occurring disorder, has
7 diabetes, has HIV. So, we basically get the people
8 that have drug use, and that's it.

9 That's not the population I've ever served
10 when I've worked in the treatment program, and I'm
11 looking at heads nodding. So, we need to be thinking
12 about how we move our evaluation, not only to have a
13 good, solid, standard that we can say, "We can stand
14 behind this," but we need to be able to move into
15 knowledge development that's really practice related,
16 that really helps the field, so the communities know
17 that this is not only evidence-based practice, but it
18 can go to scale.

19 Related, we need to know how much these
20 things really cost in the real world, because we get
21 these wonderful cost studies from our colleagues in
22 other fields, but again, they don't balance in real

1 life. We don't know how -- what it takes to actually
2 put some of these evidence-based practices. We keep
3 forgetting to do things like supervision. I would
4 like us to do studies that get CMS to pay for
5 supervision as the clinical service. That's going to
6 be my first study.

7 The final thing that, I think, and it's
8 really critical to me, is to how do we create better
9 access to our data, how do we disseminate it? So,
10 we're looking for better ways to do it. Judy was
11 handing me her one-pagers which, Judy, we actually
12 have a one-pager coming out, we're going to roll every
13 month. We're going to roll a new piece of data out,
14 just one page, with 50 words of what we think are
15 really something that happened that is important.

16 But, we're also thinking, instead of our big
17 table bumpers -- everybody knows about table bumpers -
18 - can we shorten them down? Let's just do highlights.
19 We'll put the big table-thumping part on the Web,
20 those of us who really like tables and stuff, great.
21 But, what we really want to do is say, "Here are the
22 key things that happened."

1 We're also looking at rolling out, in a
2 different strategy, so we're going to work with Mark
3 and the Centers as to how do we come up and say, "Here
4 are the prevention types of data, let's put that out
5 separately," and not having one large national finding
6 report on everything -- having different things that
7 focus on prevention issues, treatment issues, and give
8 a little bit more flexibility and a little more focus
9 to each of the areas.

10 The other thing is, how do we create data
11 points for everybody to come in and look out? That
12 means we're going to look into data points where, not
13 only our staff can look at it, but that our
14 constituents, so you could go on and say, "I want to
15 look at my State, and I want to look at, say, how many
16 people in my State are abusing versus dependent." And
17 you could punch up the number, and it feeds into a
18 field -- map field -- and where are my spots for
19 treatment? Where are my high-risk areas? So, we're
20 looking at how far down, geographically, we can go.

21 We have a lot of things to work out, like
22 how do we focus it all to work? How far down can we

1 go before we start violating confidentiality? We're
2 working on that, I think they can be overcome.
3 Technology has moved a whole lot further than when I
4 was doing my dissertation, some 20 years ago.

5 So, again, I guess what I would like from
6 you is some feedback, does that sound like we're
7 moving in the right direction, in general? We're
8 trying to balance our portfolio across the Centers,
9 working more collaboratively. And the one thing that
10 runs through everything we do, if we can just put it
11 at the beginning of every slide, is collaboration.
12 We're really working hard to build collaboration
13 across SAMHSA, and we're really working hard to build
14 collaborations with our sister agencies, and we're
15 working hard to build collaborations with our
16 constituent groups, including the Council, to figure
17 out do you have different needs? Let's figure out how
18 to meet those needs as we go along.

19 And I see this has, especially -- I'm
20 looking at, like, a 3- to 5-year plan. I was doing a
21 10- to 20-year plan, but we're going to have to think
22 that far out. Does this sound good? Do you have any

1 ideas? What kind of evaluation should we be focusing
2 on? What kind of knowledge dissemination, those kind
3 of questions, and if you have any other thoughts, I
4 would welcome them.

5 Chairperson Hyde: Okay, thanks, Pete.

6 Arturo?

7 Mr. Gonzales: Pete, I think the work is
8 extremely important in terms of the role for SAMHSA
9 and evidence-based technologies. One of the areas
10 that I would like to suggest where there's some help
11 needed is in the area of -- let's see how to phrase it
12 -- it's in the area of delivery of behavioral health
13 services via Telehealth methodologies.

14 There isn't, that I'm aware of, anyway, the
15 ability to develop what it costs to deliver that, is
16 it cost-effective, and is it satisfactory from a
17 clinical standpoint and a patient standpoint? Because
18 the Department of Commerce, in their National
19 Technology Plan, has come out with a whole host of
20 things that they want to give this country -- get this
21 country up to speed with in terms of health
22 information technology in the health area.

1 One is the delivery of medical and health
2 services through medical technology, and that's going
3 to be so important, particularly from the standpoint
4 of rural areas, that you might be able to do
5 psychiatric evaluations through Telehealth, and we
6 have been doing it. But I haven't been able to do it
7 for nothing to the consumers, but at some point,
8 there's going to have to be a charge for it. There's
9 going to have to be some evaluation of its
10 effectiveness. And I think SAMHSA could be -- take
11 the lead.

12 Dr. Delany: I'm drawing on my experiences
13 as a clinician at DoD. We did Telehealth all over the
14 world, and it was an invaluable resource. Of course,
15 you're right -- we didn't know what the cost was, we
16 just did it. So, I think there were some costs and
17 how to set it up, I think the technology has become so
18 inexpensive, now, that you can build a camera for
19 fifteen bucks on top of your screen, and there's a
20 program for \$200 that we installed on our machine,
21 that we could actually have, like, a Brady Bunch,
22 seriously, it was like Brady Bunch on our screen. The

1 only problem is teaching clinicians how to coral those
2 people on the screen. I'll look at it, that's
3 something we will see where we can go with it.

4 Ms. Stein: Mine is also kind of a health IT
5 question. As we're developing these new data systems
6 and community data systems, are you guys taking some
7 lead in working on electronic health records and how
8 these things can be integrated so they can sort of be
9 generating more out of the medical records as a
10 separate system?

11 Dr. Delany: That's something we're working
12 on.

13 Chairperson Hyde: We do have a whole
14 presentation, after all, on medical records, so hold
15 that thought and bring it back.

16 Stephanie, you're next.

17 Dr. LeMelle: This may come up later, I'm
18 not sure, but one of the issues we've come up against
19 on clinical practice is sharing of information. And
20 with the HIPAA regulations, people are very reluctant
21 to share information, electronically, that can be
22 traced back to the individual. Amongst providers what

1 I think now consumers want to share information with
2 their providers, and I have a lot of patients --
3 female patients -- who want to Skype me, or text me or
4 using all of the different means we have of electronic
5 communication.

6 And it seems, at least, in New York, there's
7 no real good standard for what the rules and regs are
8 about sharing that kind of information between
9 patients and clinicians. I think HIPAA sort of deals
10 with the clinician issue, but it doesn't really
11 address the client to the clinician issue. I'm not
12 sure if that falls in this discussion. I think, again
13 --

14 Chairperson Hyde: That's definitely
15 something you should bring up because privacy issues
16 come under Pete's area, so that's a great question.
17 Especially since Steven is listening to this. That's
18 an interesting challenge.

19 Cynthia, and George?

20 Ms. Wainscott: I would think one of the
21 most predictable risky times in the health system is
22 when the child goes from child services to the adult

1 system and they often disappear. Of course, they
2 don't really disappear, but they disappear from the
3 data in another system. There are other times when
4 that happens, the -- if there is some way that we
5 could have some accountability where it's just an
6 outcome accountability when a child is transitioning.
7 What happens? Do they remain connected to the
8 services? It is much more likely that they will
9 continue to need services. There -- I don't know how
10 -- I see so often, kids just disappear, and we find
11 them later.

12 Dr. Delany: We recently reestablished the
13 regional data meetings, like two or three public
14 health versions at a time, bringing all of the key
15 data people in. This is one of the issues -- there's
16 a corollary that happens when people are moving from
17 one treatment system to the other as adults. We're
18 still trying to get people to use the same number, so
19 a person might move from -- even with the program --
20 they might move from an inpatient program to the
21 outpatient, and get discharged with one number, and
22 they could intake with a new number. And it looks

1 like a new admission when it's really a transition.

2 So, some places are doing it, part of this
3 is with health information systems. I think Flo is
4 asking a really important question -- how do we
5 overlap and help IT issues with the health information
6 systems? They're not exactly all the right same
7 thing, but we have to make sure that they're at least
8 compatible.

9 But, it is a really important question I
10 have been giving a lot of time to. I think it is
11 something worthwhile, is the phenomena of not only
12 aging out, but just moving on.

13 Ms. Wainscott: And this is a harder one, I
14 think, but if we can come -- someday come to the state
15 where the mental health records of people that are
16 serving -- served by the mental health system, and the
17 same people served in the Medicaid system are somehow
18 connected -- I'm unaware of anyplace doing that -- it
19 just creates havoc.

20 Chairperson Hyde: New Mexico is doing that,
21 too, through the integration process.

22 Dr. Delany: We're also looking at, maybe,

1 we've been talking with the State data people about,
2 for example, we know -- John talked this morning about
3 how many people are going to move on from substance
4 abuse -- we move from the substance rolls to the
5 Medicaid rolls to make sure we're getting data back
6 from CMS, and it is probably the major topic that we
7 spent in our daily meetings.

8 Mr. Braunstein: I would like to -- I think
9 it's great, some of the areas of focus. I would like
10 to just emphasize three from my thinking of where I
11 stand.

12 One is, I think that communities need a
13 simple, but clear, clearly -- assessment tool to
14 understand the needs of their community and begin to
15 get people to talk the same language about those needs
16 so if there can be some framework that could take
17 advantage, you start out understanding the needs of
18 the community that could roll out nationally better
19 than what happens now, and in some instances, I think
20 I heard you say you were thinking of that.

21 The second thing that I think is probably
22 the greatest emphasis goes back to something I said

1 this morning. If SAMHSA could take the lead on
2 beginning to identify and put a measurable --
3 something measurable onto what is a successful outcome
4 for services provided, I just think that would be so
5 invaluable. Because, otherwise, I don't care how
6 creative it sounds to do a level of care, if you start
7 paying people for a volume of services, they're going
8 to do a volume of services -- it doesn't matter
9 whether it's creative care or the same old stuff. So,
10 getting at outcomes, and eventually tying it to
11 payment or some form of reinforcement is great.

12 And then the third item -- and it ties with
13 both of the things I just mentioned is, I think it's
14 fantastic you're moving to try and create some kind of
15 a scorecard -- a simple mechanism to measure key
16 indicators -- understanding you can go online and
17 drill down for data, especially data that's needed to
18 understand why something is not performing in a
19 certain way. I think that that would, again, get
20 people to focus on 10, 15 key measures, and not send
21 out huge reams of spreadsheets. I think it's great.

22 Chairperson Hyde: Stephanie wanted to talk

1 again, but let me ask a question, all of you, to react
2 to that. This whole issue, we sort of just barely
3 touched on this morning and said we would talk about
4 it more now, this whole issue of quality measures
5 which, I think, is partly what you're raising. And
6 for those of you that know the healthcare field, we
7 can talk about whether that -- whether they have good
8 models, or not. But what kind of guidance, or
9 direction, or input would you give us around this
10 issue of SAMHSA's role in helping to corral the many
11 efforts that are going on at developing more quality
12 measures and, say, QA, to some of the accrediting
13 bodies, NNQF, I mean, there's a plethora of people
14 trying to say, "Well, here's what quality measures
15 should be." And then, I mean, and this will come up
16 later when you're talking electronic health records,
17 they're kind of scratching their heads, saying, "We
18 don't really know what to put in there, because we
19 don't know what the quality measures should be." So,
20 it's like this funny, bizarre -- everybody's doing it,
21 nobody's doing it. So, what would you recommend, what
22 role we can play in that?

1 Mr. Braunstein: I think we need -- what I
2 intend to do in the Agency is, I've worked with --
3 over the last 20 years -- is move away from absence of
4 high-level care, like hospitalization and so forth, or
5 absence of symptoms, into the very things that the
6 people we're working with want.

7 So, basically, some measures of their
8 effective living. And I know that those kinds of
9 things are not as easy to measure out of a medical
10 record, but there are ways of measuring that people
11 are effectively -- and it gets to the recovery
12 measures, as people are in some form of desirable
13 housing, they're in employment or some other activity
14 during the day that they desire to be involved in,
15 they're in education -- again, going back to something
16 we alluded to this morning -- they have a primary --
17 if they have serious mental illness, they have a
18 primary care provider they're hooked up with.

19 Some of those things that almost are
20 parallel to our own lives -- what do we consider to be
21 a normal lifestyle, and how could we go about
22 measuring those kinds of things that the people we're

1 providing services for also want? And so, those are a
2 few of the ideas that I would have, and that we are,
3 ourselves, putting more and more emphasis on as
4 outcomes.

5 Chairperson Hyde: I wanted to pursue this
6 just a little bit, because I think it's hard. And I'm
7 totally with you, what you just said I totally agree
8 with.

9 Here's, I think, the thing we're struggling
10 with -- people are trying to set these quality
11 measures that will work inside their electronic health
12 record because that's what they're trying to move to.
13 And you can certainly think about things like, both
14 diabetic, for example, did they get a foot exam? And
15 that does have some evidence that, if they got that
16 foot exam, it actually does prevent an amputation
17 later. And that may be an overstatement, but you get
18 the point. And you can actually tell that in
19 electronic health record, whether that happened or
20 not. So, it is a measure of quality or a measure of
21 outcome.

22 And maybe quality and outcome, here, are two

1 different things, but nevertheless, you can do some
2 things like that. It gets harder, especially if you
3 keep your notion of behavioral health pretty broad,
4 because we're not just talking about people with
5 serious mental illness, or people with severe or
6 chronic substance use disorders. We're talking about
7 everybody from people getting treated for mild
8 depression in a private care office, all the way to
9 specialty care, and everything in between. So, how
10 would you think about, again, what our role is? But
11 how should we think about what are the kinds of things
12 we ought to be saying to the electronic health records
13 folks?

14 And again, I come back to this later, but
15 Pete's going to have a role in this, about what those
16 quality measurements ought to be in there. And that
17 goes, I think, fundamentally to what do we think of?

18 Mr. Braunstein: And let me just say, to
19 that example we gave, we can provide examples of
20 people attending appointments, and some other examples
21 of people doing a little more preventative levels of
22 self-care. But those are process measures, again, to

1 get to something else. Which is, that if people are
2 healthier, they use your services less, they're less
3 expensive, and therefore you create greater capacity.

4 And so we should be, ultimately, we have to
5 measure both. I think we have to go for the larger
6 picture, as -- because otherwise, I don't know that
7 we'll ever get to the point of really reinforcing
8 consumer right services, more consumer independence,
9 and treating them as equal partners.

10 Chairperson Hyde: Okay, I have several
11 people. I had Stephanie up, and then Don, Arturo, and
12 Ed and then Flo.

13 Dr. LeMelle: Going back to your comment,
14 now, I think one way that we may be able to capture it
15 electronically is to really take a systems-level
16 evaluation, as opposed to these specifics. We don't,
17 necessarily, have to ask because it will invite
18 everyone, but if you have a medical exam related to
19 something, or did you have a psychiatric exam related
20 to this? Did you have a substance abuse exam related
21 to this? And do it on a systems approach to the
22 evaluation of individuals' use of services, and not

1 necessarily to the specifics. I think that's where we
2 get cut off, at least from my perspective, working
3 with clinical records, is when you have these drop-
4 downs, what you did that doesn't fit the drop-down,
5 then there's nothing you can do about it. Whereas, if
6 it's a system, then I can actually write in,
7 specifically -- we categorize it by system, but then
8 you write the specifics in. It may be designing the
9 electronic records in that way might be more useful.

10 Dr. Delany: One of the things we're looking
11 at -- because that's our large national survey, we
12 ask, "Have you seen a physician in the last year?"
13 The next set of questions is, "Did they ask you about
14 your alcohol use? Did they ask you about drug use?
15 Did they ask you about mental health issues?" And so,
16 actually, there's a nice corollary if we want to be
17 thinking about health IT, that would cascade up and
18 down.

19 Dr. LeMelle: And then with each one of
20 those categories or systems within mental health that
21 need to be addressed, systems in mental health and
22 substance abuse that you can capture it.

1 Dr. Delany: It's not really good if you
2 make a referral if there's no place for the person to
3 be referred to.

4 Dr. LeMelle: The other thing I would say,
5 prior to this, that's on our wish list of
6 collaborations, I think that if there's a way to share
7 information, also with the criminal justice system,
8 because as you were saying, or as Cynthia was saying,
9 where people get lost, oftentimes they get lost in the
10 criminal justice system. And if there's a way to
11 share information across that system --

12 Dr. Delany: Could I, maybe, move this a
13 little bit off of health IT, because I want to look at
14 data and outcomes, as well as quality.

15 Chairperson Hyde: Don is next.

16 Dr. Rosen: Thank you very much. I was the
17 one who clapped when you said about reimbursement. I
18 very much applaud that, and I guess I found myself
19 thinking about the word "recovery" because it is an
20 attractive word. But it also depends on how you
21 define it. And I guess, how you think about how to
22 measure that word as you move forward in putting

1 together the information, and do you think about it in
2 terms of percentage of GAF, do you think about it in
3 terms of breakouts of mental illness and substance
4 abuse disorders.

5 And then the other question I had -- and I
6 don't know that I should ask another question -- has
7 to do with how could we best assess the level of care
8 that is needed for the presenting problem? It's
9 incumbent upon us to take a conservative approach,
10 because we want to do no harm. And we don't want the
11 most expensive type of a treatment, and how can we
12 bring the best scientific information to help solve
13 that?

14 Chairperson Hyde: Okay.

15 Arturo?

16 Mr. Gonzales: How do you determine -- I
17 like this idea of the systems approach, and I like the
18 idea of talking about the integration of health and
19 medical care. Sometimes I think we place a lot of on-
20 the-pedestal importance to the medical field and how
21 they screen for things. True, you can do a hemoglobin
22 A1-C to see if a person is diabetic, but it is not a

1 magic kind of -- a highly technical thing. I mean,
2 it's common-sense, hard work kinds of questions. You
3 take a blood pressure, you take a weight, you take a
4 temperature, you take an oxygen, O2 level, that kind
5 of stuff as part of the regular diagnostic
6 intervention when the person comes in. Why can't we
7 develop the same thing with regard to behavioral
8 health and substance abuse?

9 For example, if you integrate primary care
10 and substance abuse in the systems approach, when you
11 take your blood pressure and your weights and
12 everything like that, why can't you also ask the
13 question to the individual, "What is your mood today?
14 Are you feeling depressed? Are you feeling
15 enthusiastic? Have you been drinking?" Some key,
16 simple questions that will give you an indication that
17 will give you a screen of, this person is having some
18 kind of difficulty with mental health issues and/or
19 substance abuse issues. And tie those into the
20 medical universal kinds of things you do in the
21 office. And, at least start from there. It's not
22 perfect, but like you said, what's perfect? You can

1 only do so much, and it might be a start.

2 Chairperson Hyde: Ed?

3 Dr. Wang: Thanks.

4 Actually, two things. One is just to
5 follow, in terms of quality measures, one of the
6 things that, actually, I've been kind of looking at is
7 also, let's not invent something that's already been
8 built, or worked on, as when you mentioned about NSQA,
9 also added, we have the class and cultural service
10 standards as well as the SAMHSA-owned competence for
11 managed-care entities.

12 I think what we need to do in some sense is
13 to crosswalk all of those standards. Because a
14 standard, to me, in some sense reflects the system in
15 terms of quality as well as policy in terms of
16 quality. The question is, how do we pull it together?
17 I think in Massachusetts, I'm just thinking, our
18 providers, they already have been well-versed with
19 some of these standards, and actually have been trying
20 to perform the best they can under these standards,
21 and so forth. So, if there's a way to crosswalk them
22 and, with the SAMHSA leadership role, and say, "This

1 is what we looked at."

2 My other point, going back to your earlier,
3 in terms of the data platform, and I'm not a very
4 technical data person, so I'm using words, data,
5 variables -- I think this is a great opportunity for
6 us to, when you are really looking at the new system -
7 - data system -- in terms of outcome, as well, it's
8 beginning to focus onto the whole issue of race,
9 ethnicity, and language -- some way to build into that
10 system. I think especially when we talk about the
11 first three priorities: prevention, trauma and
12 justice, and military families, I think we need to
13 know who we're talking about in terms of by race,
14 ethnicity and language.

15 IOM came out with a report, a recommendation
16 last summer, specifically on how to collect REM, for
17 example, in language. So, I think there's a way to
18 build it into what SAMHSA's initiatives, I think that
19 would be great.

20 Part of it is, because we focus in terms of
21 moving away from, let's say, this is a specific
22 service, but rather looking at what we -- what we get

1 to people. Race, ethnicity, and language is only one
2 aspect. I think we have to look at geographic
3 differences: rural versus cities, cities versus
4 cities -- resources are different, everything is
5 different. So, we can also incorporate in terms of
6 that aspect of it.

7 And if we look at it broadly, now, in terms
8 of, "Okay, we have Census, who are the American
9 people," I think if we look at, then, the prevalence
10 of mental illness and substance abuse, and other
11 behavioral health issues of the population in the
12 United States and finally looking at the issues that
13 we're talking about in terms of outcomes,
14 utilizations, quality and so forth -- if we're
15 beginning, to me, if we begin to look at all of those
16 three things simultaneously or concurrently, then I
17 think we have a better picture of what the needs of
18 this country, and needs in terms of behavioral health
19 and also beginning to address in terms of a lot of
20 these partnerships that are related to social
21 determinants, political determinants, economic
22 determinants that we all know is critical towards the

1 well-being of our people in this country. So, just a
2 very broad kind of a scope of looking at it.

3 Chairperson Hyde: You might just want to
4 say a word or two, or sentence or two, about the
5 ethnicity data.

6 Dr. Delany: Actually, I did want to. I
7 really agree with you, and actually there's like --
8 it's basically, how can we slice and dice the data in
9 ways that help lay out the differences? Again, what
10 we're doing now is we're kind of looking at -- we have
11 a series of short reports coming out, and I'll make
12 sure everybody gets a copy of it, where we're looking
13 at different racial and ethnic groups that go with the
14 treatment, and looking at the different
15 characterizations -- we did one on Mexican-Americans -
16 - which basically shows there's big differences
17 between males and females going into treatment in
18 terms of what they're really -- what their primary
19 referrals are, what their primary substance of abuse
20 is, and what -- we're coming out with Asian-Pacific
21 Islanders, coming out, and we have that whole series
22 of them, where we try to break down a little further

1 with Hispanics.

2 We've got Mexican-Americans, but the
3 Hispanics got a little hard. And so we're slicing and
4 dicing the data, and that's one of the things that we
5 think is really important.

6 But, we're also looking at can we
7 geographically break it down so we get more urban and
8 rural, and looking at, maybe, clumping things
9 according to regions to demonstrate.

10 One of the things we're finding out is,
11 problems are regional. For example, methamphetamine
12 is not a big problem in a number of areas of the
13 country, but in certain areas, like in the Northwest,
14 and the Southwest and the Midwest, it's a huge
15 problem. But in, say, Florida, it's not a big
16 problem.

17 So, regionally, this are different. And
18 that helps us think about planning differently. And
19 that's one of the things we're trying to work with the
20 Centers on, is to get their ideas, and also to grab
21 from you is, how do we get the data out in ways that
22 help people think about planning and using the

1 resources in a different way?

2 And I think it is, we're looking at a whole
3 lot of different demographic issues, now, that we're
4 trying to -- much as race and ethnicity, language --
5 that's a little harder, that a good point we'll have
6 to look at. But this gets at a quality measure, too.
7 We talk about what is good treatment or what is a good
8 outcome, maybe a good outcome -- because there's some
9 that are process measures, but a good outcome measure
10 is if you're in a program that provided you services
11 that met your needs. And it's not just -- so, part of
12 it may be that you're in a program that actually --
13 I'm thinking of the hearing-impaired or the deaf
14 community, where they're just using a sign language
15 interpreter, but they don't have -- that is not the
16 same thing as working within a group of people who are
17 all hearing impaired, or deaf.

18 So, it raises an interesting question about
19 quality measures and what is quality treatment. And
20 so there are quality outcomes we have to think about
21 of what are good treatment outcomes versus what are
22 good recovery outcomes.

1 It's like something -- we need to know what
2 happened to you in treatment, was it a good idea, what
3 happened when you were in prevention services, was
4 that a good prevention program, but then later down
5 the road, we need to be figuring out how do we measure
6 these things later, so it's an important question.

7 Dr. Wang: First of all, thank you for
8 including ethnicity and even ethnicity itself is a
9 challenge, because when you mention about Mexican-
10 Americans I would say that, well, geez, you know, we
11 don't have all that many Mexican-Americans in
12 Massachusetts, but we have a lot more Puerto Ricans or
13 Dominicans. So, I guess what the lesson learned is
14 each State is different. And also, geographically
15 each city can be different.

16 Then it goes back to, how do we set up the
17 data platform so that the data is meaningful to that
18 State, maybe to that specific city, because I'm
19 thinking, okay, trauma. One group that I'm thinking a
20 lot about trauma is our refugee population. So, I'm
21 thinking, Long Beach, California has a large Cambodian
22 population, Massachusetts -- Lowell -- has a large

1 Cambodian population. So, how do we do, in terms of,
2 be really inclusive with the data but also at the same
3 time you would say that this would be much more
4 helpful for Asians.

5 I don't have a solution for that, but I
6 think it is a great first step. I think SAMHSA
7 actually can show some leadership, maybe, through some
8 standards or whatever quality to say that, how do you
9 measure that based on your population census and based
10 on other factors, too, such as trauma or other types
11 of determinants. And it's also critical for the well-
12 being, the overall well-being.

13 Chairperson Hyde: We have Flo, Kate and
14 Cynthia. And while you're finishing up on this one,
15 I'm going to go take a call, and Toian will start you
16 on the next one.

17 Ms. Stein: I just wanted to echo Ed's great
18 idea, and his first point -- both were great. But we
19 still have to produce outcome data for all of these
20 different systems, the different accrediting bodies,
21 JCAHO, our hospitals are required to have that. The
22 CMS approval -- CMS has them for SAMHSA, there must be

1 some commonality to that. We could crosswalk and pull
2 together to reduce the data set with the requirements
3 of a lot of different systems.

4 Dr. Delany: I've got that starred three
5 times. We can actually do that, literally more
6 rapidly than the other stuff.

7 What's interesting, too, is here's my real
8 concern -- having done CARP and JCAHO, and a couple of
9 other accreditations, if we get to the end of it,
10 we'll find out it might be useful.

11 Ms. Stein: There would be a great showing
12 of SAMHSA leadership. If none of them were very good,
13 that might be the whole issue.

14 Ms. Vaughn: We'll take the last two.

15 Kate?

16 Ms. Aurelius: I, too, wanted to say that it
17 was great doing the crosswalk. And I think a lot of
18 room for, as you look at how the medical community has
19 injured itself over time, there have been a lot of
20 fits and starts, so you have to make room for some who
21 thought this was a good idea, but this is not
22 ultimately how we want to measure it, so you have to

1 kind of think out of the box. I always encourage us
2 to show in there, just a satisfaction question when
3 we're measuring outcomes, that what the first
4 experience with the healthcare delivery, no matter
5 what it is. Because I think even if you got really
6 excellent care but you thought it stunk, it's not
7 going to be very good care for you.

8 Ms. Wainscott: I would share with you a
9 conversation that I recently had with the Director of
10 our Georgia Mental Health Consumer Network. And we
11 were talking about how to measure how well we were
12 doing in a project, and we talked about all of the
13 stuff, you know, we talked about some direction
14 process, and Sheri said, "Why don't we just ask people
15 if their life is better than it was when they
16 started?" And we said, "Drill down on that, Sheri,"
17 and she came up with two things that I think were
18 brilliant that really goes to your question. "Do you
19 have goals? Are you making progress toward meeting
20 them?" Those two things -- it puts the focus on the
21 recovery process, and it acknowledges the person in
22 that process as the expert on what is happening. I

1 thought that was pretty smart.

2 Dr. Delany: Thank you.

3 Ms. Vaughn: Thank you, Pete.

4 We'll now move to the next item on the
5 agenda. Mark Weber, the Director of the Office of
6 Communications -- you can find his presentation in
7 this document on page 21, item number 10. And, in
8 addition, the document is on page 11 and item number
9 10.

10 PRESENTATION OF MARK WEBER, DIRECTOR,
11 SAMHSA'S OFFICE OF COMMUNICATIONS

12 Mr. Weber: Well, hopefully I'm not the item
13 on the agenda, it's the Public Awareness and Support
14 initiative that is. I'm going to start out by
15 modeling something you're going to be seeing from
16 SAMHSA and hopefully when you saw Pam start out this
17 morning, she had a Power Point that looked very
18 similar. So, as I walk through this, you'll see that
19 it matches what Pam's presentation was, and you'll be
20 seeing Fran and Westley, and Kathryn, and others
21 around SAMHSA starting to use a similar Power Point.
22 So, no matter where you go -- if you like it, or don't

1 -- you will know it's a SAMHSA Power Point, so we're
2 getting into that branding.

3 But, where I want to start is, anyway, that
4 I'm Mark Weber, Director of Communications here at
5 SAMHSA, and it's a great time to be here with many
6 great new opportunities. And I would say, here's my
7 new opportunity, and then what we're going to be doing
8 is talking about how to communicate to the country
9 that behavioral health is an essential part of health.
10 And I think we're going to be quite a challenge, as
11 well.

12 But one of the things I started thinking
13 about when I was looking at, okay, so we have SAMHSA,
14 we get a chance to keep going with the best, but
15 really reshape and look at what else we can do. I did
16 a little research, and it was pretty interesting. I
17 found out that the national High Blood Pressure
18 Education Program was established in 1972. And it
19 demonstrated its success and it demonstrates the
20 opportunity to use a strategic planning framework for
21 communications and appropriate marketing mix.

22 The year the program began, less than a

1 fourth of the American population knew of the
2 relationship between hypertension, stroke and heart
3 disease. Today, more than three-fourths of the
4 American population are aware of the connection. As a
5 result, virtually all Americans have had their blood
6 pressure measured at least once, and three-fourths of
7 the population have had it measured every 6 months.
8 So, in a matter of 40 years, if you were to go to your
9 doctor's office and they didn't take your blood
10 pressure, you would think there's something wrong with
11 your doctor.

12 So, let's project that forward -- working
13 for Pam, I really don't have 40 years, but if, in 40
14 years, you were to go into a physician's office or
15 some kind of health clinic for some kind of visit and
16 they didn't ask you about how you were feeling, or if
17 you were drinking too much or your drinking habits,
18 you thought, "My gosh, they didn't ask me that,
19 there's something wrong with this place, I need to go
20 someplace else," so that we create a standard of care
21 and expectation among the American public that these
22 are part of normal, routine parts of healthcare,

1 health services, things that you would ultimately --
2 and I'll get into my goal here -- that you would seek
3 help for a mental health condition or substance abuse
4 disorder with the same urgency as any other health
5 condition.

6 And I'm going to back up a second, and
7 before you get to that, what we need to do is work
8 very hard to increase the understanding of mental
9 health or mental and substance abuse disorder
10 services, prevention, treatment services, so that we
11 achieve the full potential of prevention.

12 So, first of all, we need to be working on
13 achieving the full potential of prevention,
14 understanding that substance abuse can be prevented,
15 and we know how. We know that many mental disorders
16 can be prevented, and most importantly, we can
17 mitigate the disability associated with them.

18 So, how do we go about raising that
19 awareness? And, again, to achieve the full potential
20 of prevention, and then at the same time have the
21 opportunity for people to seek help with the same
22 urgency as any other health condition.

1 I would say the good news is, most Americans
2 believe addictions can be prevented. A larger
3 percentage believe that recovery is possible, and
4 again, another 66 percent believe that with treatment
5 and support, people can recovery from mental illness
6 and lead normal lives.

7 I also have, on the other end of the
8 spectrum, there's a large proportion of people who
9 think less of somebody they knew had an addiction.
10 There are people who think people with mental
11 illnesses are violent and dangerous, and so these are
12 taking the pulse of the country. This data came from
13 just popping the question into a Gallup Poll type of
14 thing and seeing what the general attitudes were.

15 I love dirty market research, it tells us an
16 awful lot, and I often say it's the for-profit
17 marketing people that have kids buying video games and
18 it is not us in the public health community that have
19 them adopting the behaviors we would like to see
20 happen.

21 So, digging into the data a little bit
22 further, as Pete was talking about, at the National

1 Survey on Drug Use and Health of the 10.6 million
2 adults who reported an unmet need for mental health
3 services, half of them -- well, I'm sorry, I got that
4 wrong -- 10.6 million people reported a need for
5 mental health services. About half of them, 5.1
6 million, said they had an unmet need. And when you
7 asked them, why didn't they get the help that they
8 needed, the largest reason for it, from all sources,
9 was their health insurance didn't cover it, they
10 couldn't afford the care. So, let's hope the
11 Affordable Care Act will remove that.

12 But the second-largest part said they had no
13 where to go to get help. It was like, my gosh, that
14 is something we probably can do a lot about without a
15 lot of money, and digging into the people with
16 diagnosable substance abuse disorder, asked the same
17 questions, the number one reason why they didn't get
18 help, health insurance coverage, number two, they
19 didn't know where to go. And I was like, again, wow,
20 that is something we can do something about.

21 So, we started looking into what can we do
22 here at SAMHSA around this. And a couple of things

1 that we're going to be undertaking. First of all,
2 we're going to be looking at some of these surveys
3 that we can do of American attitudes, public
4 attitudes, and set a baseline for a couple of key
5 topics. Maybe, again, haven't decided this yet, still
6 working on it, and ideas are certainly welcome -- that
7 is what this is all about -- but finding out how many
8 Americans report whether they've been screened for a
9 mental or substance abuse disorder -- have you been
10 screened? So, start doing a push and a pull strategy
11 around communications, finding out if they know where
12 to go. I mean, there it is, household surveys says
13 people don't know where to go.

14 Another one we might be looking at is, what
15 steps are they taking to prevent mental or substance
16 abuse disorders? Have they taken a step? What would
17 it be? And again, this is great, kind of, stuff that
18 helps us shape our messages and programs. And on top
19 of that -- so that would be, we'll be setting that as
20 a baseline, and hopefully we'll be picking out those
21 questions in the next couple of months so we have a
22 baseline. Actually, it's in my performance plan,

1 which needs to be done by September 30th, so we'll
2 have questions by then. By then, I'm sure.

3 And then what we need to do is start looking
4 across the Agency in terms of the ten strategic
5 initiatives and providing support around what is the
6 communications component of that, and making sure that
7 we start aligning the resources within the Agency
8 around the ten initiatives with what is coming out of
9 the Agency, and making sure it is a consistent
10 message, making sure efforts are directing people in a
11 similar path to a similar Web site.

12 So, how we're starting to pull together the
13 entire Agency to create that consistent message.
14 Number one, you've seen the Fact Sheet that was passed
15 out to you earlier this morning; it's pretty amazing.
16 Every time I get a fast turnaround or a controlled
17 correspondence for the Secretary, I go to that Fact
18 Sheet, and I have an answer to almost every letter
19 that comes into this Agency in terms of a public
20 response.

21 So, we have -- and then we have the
22 reframing of the mission, reducing the impact of

1 substance abuse and mental illness on America's
2 communities. Now, we need to get that information
3 out, creating the new look and feel -- you're starting
4 to see a little bit of it here, developing the core
5 messages. You saw the Fact Sheet. That's essential
6 to prevention.

7 Now, I'm going to -- prevention is
8 effective, and people recover. I got it a little
9 backward there -- and then we can use those kinds of
10 key messages in our correspondence and our
11 publications.

12 The other thing we're doing is consolidating
13 our Web sites. SAMHSA has 88 Web sites, and what's
14 amazing is, there's not one dollar or promotion or
15 advertising going into any of those Web sites. Think
16 in terms of any company trying to promote something,
17 and make the general public aware. No wonder we're
18 confusing people and making it difficult for them to
19 find health services.

20 So, the concept around consolidating the Web
21 sites, and again, consolidating SAMHSA presence is, if
22 you remember the public or if you're a person working

1 in the mental health area instead of -- and I don't
2 mean to pick on any one particular area, but if you're
3 interested in housing and homelessness. Well, instead
4 of looking for the homelessness resource center, you
5 call SAMHSA because you know SAMHSA has the expertise.
6 If you're looking for substance abuse treatment, you
7 shouldn't be looking for the substance abuse locator,
8 you should be calling SAMHSA, because you know SAMHSA
9 has the expertise. If you're looking for the latest
10 prevention models, you shouldn't be looking at NRAP,
11 you should be looking at calling SAMHSA, because
12 SAMHSA has the expertise. So, consolidating the
13 concept of this is the place where the expertise
14 resides on particular topics, as opposed to trying to
15 set up 88 different, individual Web sites, all
16 competing in a very limited market space with no
17 advertising dollars. That's the definition of
18 insanity, or something.

19 And so, anyway, bringing all of the Web
20 sites together, we actually may have the new Web
21 presence up and ready by the end of June.

22 Expanding the use of social media -- you've

1 heard that Steven is here, I'm looking forward to
2 working with him and getting his ideas, but the bottom
3 line -- it's been interesting. We're technically not
4 allowed to have social media sites in the government,
5 so we don't click onto the current SAMHSA Web site and
6 sign up to our Facebook page or anything like that,
7 just pretend you don't see it. And it's quite amazing
8 what a great following we have already. The staff
9 that are monitoring those sites have been actually --
10 we've hired somebody from the Department and who ran
11 the food.gov site and he said, "I can not believe the
12 passion of the people who have signed up for our
13 Facebook site, and the people who are following us on
14 Twitter," he said, "It is incredible."

15 Even at the Department level in terms of
16 over the last year and how everybody got so excited
17 about the flu. And it's a very important thing, but
18 it paled in comparison to what do you see on SAMHSA,
19 even though we're not even supposed to have this yet.
20 So, we will be growing that area. And Kim has worked
21 very hard with the Department, we need to check the
22 integrity of our computer systems, and at the same

1 time, we need to be able to communicate with the
2 public.

3 Ms. Vaughn: Are you ready for a question?

4 Ms. Stein: Can you share what you have to
5 do to make it okay for government to do this? Can the
6 States do it?

7 Mr. Weber: Oh, sure. So, any use of social
8 media -- expanding the use of social media -- it's all
9 about using the technology that is most effective at
10 reaching the target audience. So, if you want to, we
11 should be able to Facebook, if you want Twitter, we
12 should be able to do Twitter. The single 800-number -
13 - we have multiple 800-numbers at SAMHSA, we've done a
14 really good job of bringing those in. But again,
15 coming in with a single point of entry -- less
16 confusion, less numbers of people. Today, with the
17 technology available, it doesn't matter where that
18 call is going, as long as you have the infrastructure
19 in place to connect people to what they're looking
20 for, that's what's important. Making the connection,
21 and then they can say, "Gosh, I called SAMHSA and they
22 did a great job of getting me where I needed to go,"

1 versus, "I called that number and I don't know what
2 happened."

3 And then down to communications plans for
4 each of the initiatives, much like Pete and coming up
5 with the quality and data measures for each of the
6 initiatives, actually coming up with the
7 communications framework for each of the initiatives,
8 we'll be working with the initiative leads, develop
9 the template that we will be applying, so that
10 communications is part of the initiative from the
11 beginning, as opposed to, "Oh, we've come up with this
12 initiative, and now we want to communicate about it."
13 If you come up with the initiative and you haven't
14 taken the communication mode into consideration from
15 the beginning, you're probably going to miss your
16 mark. So, we have lots of experience at doing that.

17 We have lots of experience at doing very
18 effective communications deployments in our programs.
19 So, looking forward to that, it's going to be quite a
20 challenge, it's a huge lift. I've got somebody in the
21 Office of Communications back here doing that, anybody
22 here, stand up? OC? Come on.

1 [Applause.]

2 Mr. Weber: Last year that team, we managed
3 25 million contacts with the public. Actually, I
4 can't think of any drama with that, except somebody
5 who got two packages confused and she got slippers and
6 she thought it was coming from SAMHSA.

7 But, just for example, in the month of
8 September last year, which is our highest media month,
9 with the Recovery Month and Household Survey, we got
10 2,000 articles in the newspapers across the country,
11 that was newspapers, about \$10 million worth of
12 advertising for SAMHSA in that way. And our volume
13 has been going up, and our media coverage -- great
14 stuff, with the data that Pete Delany was talking
15 about. It was no accident that we released the data
16 on substance abuse treatment on Mexican-Americans on
17 Cinco de Mayo.

18 Just to pick up on the other thing on
19 mothers and depression and smoking on Mother's Day.
20 We just have a little bit of fun with those kinds of
21 things.

22 And with that, I'm open to your suggestions,

1 ideas, what you've seen that's great, what's working,
2 things you would like us try to do and see what is
3 possible.

4 Yes?

5 Mr. Gonzales: The question I have is, how
6 do you incorporate what you want to incorporate,
7 National Advisory Council, to communicate?

8 Mr. Weber: How do I want to do that?

9 Mr. Gonzales: The issue is, we have a group
10 of individuals here from around the country that we
11 come and we meet. And it seems to me that there's
12 some PR or some advocacy, or whatever in our
13 respective communities and with our respective
14 constituents and colleagues. And it seems to me like
15 -- I don't know how the other Council members feel --
16 but that might be a good way.

17 Mr. Weber: I will tell you that the way
18 that it worked in the past -- and I expect it will
19 continue to work, and again, I'm open to your ideas if
20 there are areas you're particularly passionate about,
21 and I know about, I certainly -- we will make the
22 effort to funnel you information in advance, or as

1 close to advance as possible, so you can be part of
2 our voice as information rolls out.

3 Mr. Gonzales: That's Mr. Gonzales: not
4 what I'm talking about, I'm thinking something a
5 little bit different. I certainly think that is
6 useful. But, please, I don't want you to think
7 there's ego getting involved, here. I mean, you have
8 a very effective package, here. SAMHSA, the
9 prevention, treatment, and another page that says,
10 "And we're listening to you, we're listening to the
11 country," which pictures of the Advisory Council
12 there, where they're from, what their passion is, and
13 their interests. If they knew that my buddy, here,
14 Marvin was involved, they could say, "Hey, we're being
15 represented on this Council by people that understand
16 our issues," or whatever.

17 I'm just trying to say, each of us brings
18 something unique and a new passion.

19 Mr. Weber: Thinking out loud that's what
20 this is all about, now, but even as we develop our
21 social media opportunities for the Advisory Council
22 efforts, what are the opportunities in terms of

1 speaking and, of course, you can, as well, take that
2 Fact Sheet that Pam handed out this morning and build
3 talking points around that, why mental health is
4 essential to health and treatment is effective. So,
5 that's part of the tools we're starting to provide, we
6 can certainly provide more and we will certainly think
7 in terms of opportunities to use the Advisory Council
8 members for social media opportunities. And also in
9 the past, sometimes, as government officials, we get
10 in a bind about what we can talk about and what we
11 can't talk about and sometimes Advisory Council
12 members have an opportunity for us in the media, so
13 we'll think about those, as well.

14 But, lots of opportunity, and we really keep
15 struggling with how to take full advantage of that
16 opportunity to work with you all and any ideas in that
17 area are welcome.

18 Ms. Aurelius: I have more questions for you
19 on the social media. As a Medicaid agency, we're
20 struggling with social media and how to use it to
21 further the education of members around preventative
22 health, for example, and how you control -- it's

1 another way for people to reach you, and how do you
2 staff that and how do you manage that?

3 Mr. Weber: How do you staff it and manage
4 it? We're entering that whole big, brave world. I
5 think, conceptually, a way of looking at it, here at
6 SAMHSA, given the staff resources are limited and
7 there is a command and control structure in
8 government, as open as government has become,
9 relatively speaking, which is great -- once, and
10 again, this is my approach at this point, we go
11 through a lot of energy and effort to come up with --
12 for lack of a better word -- clear language.

13 I mean, every press release that comes out
14 of this Agency goes through a vetting process through
15 the entire Department, believe it or not. So, once we
16 have that language, then that is information that we
17 can use for a purpose. So, we can use it on the
18 Twitter account, that's what we're doing right now,
19 and use it on the Facebook. So, we're not creating
20 new content, it is using the content and what is a
21 transmedia approach. So, no matter how you enter into
22 the Agency or enter into the dialogue with the

1 Agency, what medium you want to use, the same
2 information is there.

3 So, it's going to be a huge challenge, as we
4 ramp this us, and more and more people join our
5 Facebook page.

6 Ms. Aurelius: So, you will be using it to
7 push information out as well as get information in?

8 Mr. Weber: Yes.

9 Ms. Aurelius: Right now, Arizona Medicaid
10 is 1.4 million people and I can't get my head wrapped
11 around how are we going to stop that. You have the
12 entire country that can reach out and touch you at any
13 time. How are you going to respond? It's a basic,
14 standard language, you know, you're going to get a
15 request and on the planet.

16 Mr. Weber: And another part of that is, I'm
17 picking a number out of the air, but 80 percent of the
18 questions are the same. And so, dealing with a lot of
19 Frequently Asked Questions -- we do that frequently --
20 we already have a Frequently Asked Questions site on
21 the Web page, and so using the Frequently Asked
22 Questions approach and conceptually, I can see that --

1 I can't say it will take less staff, but it will be a
2 more efficient way to reach more people so that if you
3 have a genuine following in your Facebook page, that
4 that takes care a big chunk of your audience, going
5 through Facebook. If we have an email blast, that's
6 actually time-consuming, because we're always updating
7 the distribution list. So, that takes a lot of time
8 to reach 500 people. But, our Facebook page, up in a
9 month, already has 3,000 people on it. So, there are
10 efficiencies.

11 Ms. Aurelius: Sure.

12 Do you have policies when people post PHI,
13 and who's going to monitor it, or does it disclaim it
14 all?

15 Mr. Weber: We have a disclaimer up about a
16 respectful place, and policies, and rarely have we had
17 to monitor or take something down. So, it's been a
18 respectful community. And I'm confident something
19 will come up, and we have policies in place to remove.
20 And I'll be in the middle of it, I'm sure.

21 Ms. Vaughn: Judy, and then Marvin.

22 Ms. Cushing: Kudos to you for looking at

1 consolidating the Web site. That has been hugely
2 confusing, and that's terrific, along with the
3 consistent core messages, I think that's really
4 terrific. I'm interested in hearing more about your
5 hot topic Fact Sheets, because those are things sent
6 via email and can be really, really helpful, to
7 constituents, to the public, in general, to SAMHSA's
8 partners. Because that is easy talking points for the
9 media, so when you want somebody in Tuscaloosa,
10 Alabama to speak to an issue that is salient with
11 them, and they could be, actually, get more response
12 from the media when they have something in front of
13 them, how will you keep those fresh, and what's the
14 plan? Give us a little more information on that?

15 Mr. Weber: What's the plan? The plan is,
16 first of all, we're going to start out with what we
17 have, and make sure we have hundreds of Fact Sheets in
18 this Agency. And so we're starting with what we have,
19 cataloguing that, making it look and feel the same, so
20 it's uniform, and then we're going to start -- and
21 again, I'm going to pick the 20 hot topics that we
22 know are going on today, and put together something

1 very much like the 10-page document that was handed
2 out this morning, so if we can start from the same
3 page, and then as new information comes along and we
4 have our Fact Sheets categorized, and a new study
5 comes out, "Oh my gosh, this will be great, it fits
6 under Trauma and Justice, so let's put this
7 information under Trauma and Justice," so we have a
8 way to catalogue the topics -- cataloguing in a way to
9 regularly update. And I'm looking at putting them on
10 a schedule for review. But that doesn't mean if
11 something new comes up that we have to wait till the
12 schedule.

13 Ms. Cushing: One of the important elements
14 that will be terrific, just to let the world know they
15 are available, because that will be so helpful when
16 the local media calls people, they can just grab that
17 off your Web site, or whatever. So, the more you're
18 out there with the Fact Sheets, was last updated on
19 blah, blah, blah.

20 Mr. Weber: Everything will be dated. In
21 fact, it was great to hear Pete talk about the State-
22 level data. As I was driving here this morning, they

1 were talking about they had State-level data for
2 Maryland for SAMHSA, and I was like, "Oh, this is
3 great," so that localizing and making it relevant to
4 communities -- you all know that.

5 Ms. Vaughn: Marvin?

6 Mr. Alexander: One thing, and I know if you
7 post things on the Web site, I was just wondering if
8 there was an alarming post, for instance, a teenager
9 contemplating suicide, if you had an immediate
10 response to that individual for the services in a
11 local community -- how would you handle that
12 situation?

13 Mr. Weber: I will tell you that individuals
14 who suggest, potentially, suicide -- we have probably
15 one of the most responsive government agencies and
16 capacity in that particular topic that I've seen,
17 anywhere. We, on a regular basis, deal with
18 individuals suggesting that they're considering
19 suicide. We can have the local crisis center tracking
20 down that individual in a respectful way to find out
21 if they need help. And what kind of assistance can we
22 provide. I know Judy has been involved in a number of

1 those, and we get them from all over the country.

2 Mr. Alexander: I'm thinking, particularly,
3 through the social networking sites where, if there is
4 a post, and there's not constant monitoring, if they
5 send a message to the Facebook account, it wasn't to
6 respond, and it's not calling in?

7 Mr. Weber: Well, these are also, and again,
8 suicide prevention area, these are also coming from
9 Web posts, emails, and the site is always being
10 monitored. So, if someone sees something and says,
11 "We need to check this out," we have a routine in
12 place, here at SAMHSA to get back to the individuals.
13 And obviously, all of this comes with a tremendous
14 amount of risk. So, the option is not doing anything.
15 I don't think that's acceptable. That's why we have a
16 Facebook page and a Twitter account already. We
17 assume some risks, there. And when something happens
18 major on a government Web site, we will all hear about
19 it, and there will be some new policy, and it will
20 cripple us for awhile, until we figure out another way
21 to fill our mission and reduce the impacts.

22 So, it is all new to everybody, and we have

1 to be smart about how we approach it. I don't want to
2 be cavalier, but it is a whole new world. And we're
3 going to try to do our best.

4 Ms. Vaughn: Cynthia?

5 Ms. Wainscott: It seems to me like you're
6 talking about two very different things. One, it
7 sounds like you've got a brand at SAMHSA and you have
8 a plan, you have a beautiful description of what you
9 want to say, you have an elevator speech, you've got
10 your message ready to go, and I think we can believe
11 that that is on its way.

12 The second thing, however, is selling the
13 message. And unless we have people in local
14 communities taking that message, I don't believe we'll
15 be optimally effective. We may be smiling from ear to
16 ear when we talk about the blood pressure campaign in
17 the 1970s because when the National Institute of
18 Mental Health did their first-ever education campaign
19 about mental illness, they used that model. And the
20 folks who did that followed their model exactly, and
21 what happened was, we went from a place where talking
22 about ending depression used to be like talking about

1 having cancer -- you just didn't do it, you didn't
2 believe it, you didn't think it was there, it was
3 embarrassing, to a place now where my daughter goes
4 into buys groceries and the person she buys groceries
5 from knows she has depression and it is successfully
6 treated -- it's perfectly safe to do that. That
7 didn't happen in Washington, it happened in local
8 communities.

9 Now, you'll hate it when I say this, Mark,
10 but you asked for suggestions -- use that model from
11 SAMHSA to find local partners -- and they did it on a
12 State-by-State basis and started out in 12 and ended
13 up in something like 45 -- who understand and agree
14 with your message and have the skills or the
15 willingness to learn, to have the contacts in their
16 communities. Then, minimally supported field dart
17 partners got \$3,000 -- that's not enough today, this
18 was in the 80s. It wouldn't take huge amounts of
19 money -- bring them in, give them training, technical
20 assistance, materials, launch them, you won't believe
21 what they will do. That's a lot of work, but you
22 would multiply your voice like you can't imagine.

1 Mr. Alexander: I have an idea, and one of
2 the things that no commitments, but ideas -- one of
3 the things we failed to do on a systematic basis here
4 at SAMHSA is take advantage of the vast network of
5 grantees that we have. And so we're really focusing
6 some energy on how do we use that network of thousands
7 of grantees -- this is the front line of behavioral
8 health across this country and help work with them to
9 get the message out.

10 So, I can't say for \$3,000 for each grantee,
11 but I do know we bring every grantee to Washington for
12 training, there's an opportunity there. And so we're
13 thinking in those terms, as a possible first step in
14 terms of the mass marketing.

15 Ms. Wainscott: I think that's a good idea,
16 but I would suggest that we think about something more
17 focused than that. In other words, if I've got a
18 grant to do substance abuse prevention, I'm mostly
19 going to be spending my energy on spending about 150,
20 or 200, or \$300,000 to get it done right. I suggest
21 you need a cadre of people whose focus is getting out
22 the message -- behavioral health is essential to

1 health, prevention works, treatment is effective and
2 people recovery -- as your primary connection with
3 you.

4 Mr. Weber: Got it.

5 Ms. Wainscott: Then, I want to say thank
6 you for the way that you have scrubbed virtually all
7 of the efforts for physical health out of these
8 materials. We used to hear a lot about physical
9 health and mental health and from the new guys we've
10 heard incessantly about what is physical about the
11 brain, and that we're furthering the separation when
12 we talk about that. And you have said numerous times,
13 mental health and other health, behavioral health and
14 other health, general medical health, and that has not
15 been easy. Thank you.

16 Mr. Weber: I appreciate the recognition.
17 It's not me, it's a whole group of people here at
18 SAMHSA who finally got that message.

19 Ms. Wainscott: I suspect you're driving it.

20 Dr. Rosen: How much of your efforts are to
21 consumers? And in looking at the material you
22 distributed, there isn't much mention of material

1 headed for providers, except on this sheet of SAMHSA's
2 role. And it seems to me the idea of using grant
3 recipients as a means of getting the message out is
4 great, and providers as a means of getting the message
5 out, are patient and consumers, and I just wanted to
6 know how you think about that.

7 Mr. Weber: What I think is you can award
8 grants to lots of communities and create change in
9 those communities. I also believe that through
10 communications and marketing you can target a segment
11 of your market and create systemic change. I think
12 providers are one of those opportunities we have to
13 create systemic change.

14 Interestingly enough, because opportunities
15 show up on your doorstep every once in a while, Kaiser
16 Permanente and the AMA have reached out to SAMHSA to
17 say -- and Kaiser is interested in some kind of
18 project around depression screening and interested in
19 doing something around prevention. Just two calls
20 that recently came in.

21 Okay, let's get Fran involved, here, let's
22 get the programmatic aspects, what are they looking

1 at, and alignment. So, somebody's been knocking at
2 the door, we have to welcome them in, and also to
3 create that systemic change, again, using the media
4 that is most receptive to the audience.

5 Ms. Marsh: I just wanted to respond to the
6 comment earlier and embellish a little bit on Mark's
7 response. If there were a suicidal remark on
8 Facebook, just mention that we're already getting a
9 lot of letters -- letters and emails -- that people
10 are writing the President when there's some suicidal
11 or potentially suicidal content. We've gotten, I
12 think, about 550 of these since January. So, that's a
13 very direct funnel. So, as soon as they get them,
14 they're coming directly here once they hit the White
15 House, so we have set up something similar. And as
16 Mark was saying, the people who work on these are
17 extremely diligent on trying to figure out the clues
18 and track down the individual and see if they need
19 help. It was a good thing to bring up, and we are on
20 it, thanks.

21 Mr. Braunstein: Let me just say, Mark, that
22 I'm very impressed with the overall plan and it sort

1 of parallels something that we've been trying to do in
2 Fairfax, as well, on a local level. Kind of mix in
3 communications, marketing and branding. Can we, as
4 National Councilmembers, maybe this isn't your job
5 alone, but this would be all of the strategic
6 initiatives I would really like to be able to keep
7 track of the progress we're making. And I assume
8 others would, aside from this group, do we -- is there
9 going to be a mechanism where we will be able to kind
10 of track where they're going and how well they're
11 doing, and what's working and what's not.

12 Mr. Weber: I believe the answer -- well, I
13 know the answer is yes. Each of the ten initiatives
14 we're required, and designing to have, specific
15 outcomes that report on a regular basis as to the
16 progress of the initiative.

17 And so in the particular case of the public
18 awareness and support, I'm looking at some public poll
19 numbers to see if we are actually having an impact.
20 Of course, obviously there will be things that happen,
21 the alignment of resources that need to happen to
22 impact those big national numbers. And again, all of

1 the initiatives will have some outcome measure that
2 will be able to do the tracking.

3 Chairperson Hyde: This is not exactly what
4 you asked, George, but just so you know, this is not
5 just a plan that's going on the shelf. We really are
6 -- at all of our executive team leadership meetings,
7 at least one or two of the leaders on the initiatives
8 are reporting out, so the whole management team and
9 leadership team is aware of what's going on. We're
10 really focusing on how we make sure, internally, we
11 know what is going on about this. I think you will
12 start to see some of this by what comes out in our
13 phase, what comes out in budget requests, et cetera.

14 But you're raising a great question and I
15 think Mark's answer is absolutely right -- we have to
16 figure out a way to get that out to the world,
17 constituency, the behavioral health field about what
18 is happening with these initiatives.

19 Mr. Braunstein: Just a suggestion, and this
20 may be too often, you will have to determine how
21 often, but we get those weekly, kind of, updates and
22 maybe once a quarter or something like that -- even if

1 not all of the initiatives, initiatives where there's
2 been just an update on those would actually be very
3 interesting. And I would really look forward to
4 seeing that, because I do believe that there will be a
5 lot of work on these. And so it's a matter of being
6 able to track where they're going, if it's possible.

7 Chairperson Hyde: Great, thanks.

8 Flo, then Arturo, then we'll wrap up.

9 Ms. Stein: I just wanted to say I think the
10 material that SAMHSA produced is a great example of
11 the materials we need for local people. They love
12 getting those things, they use them. They don't have
13 budget to do that stuff, usually, themselves, so that
14 is really -- that is working very nicely.

15 And I was looking at television the other
16 night and I saw Dr. Clark.

17 Mr. Weber: The Road to Recovery television
18 show series? Yes, I think we're in 40 million
19 households. And all of the shows, if you're up really
20 late at night, are on recovery.samhsa.gov.

21 Chairperson Hyde: I had the pleasure of
22 being on one of them and Mark was on one of them

1 yesterday along with another panel of people. So,
2 somebody from SAMHSA is on there, I think, every time
3 they do it.

4 Okay, let's see, the last one, Arturo?

5 Mr. Gonzales: I like Cynthia's idea -- I
6 like the idea of getting, as they did with the blood
7 pressure, to give Marvin, myself, and Cynthia a report
8 --

9 Mr. Weber: Be careful what you wish for.

10 [Laughter.]

11 Chairperson Hyde: We are actually trying to
12 think about, if we produced these things that are more
13 consistent in message and look, and whatever, that we
14 do want to use our associations, and you all are
15 touching another thousand people behind you, we would
16 like to get that stuff out so you can then help take
17 that. We can't possibly do this all by ourselves.

18 Ms. Wainscott: What I was suggesting was
19 that we have a program -- and this would be a lot of
20 work, and it can't be done without forethought, but
21 to, perhaps, select an organization who shares our
22 values, who believes this, who would commit to make it

1 part of their organization's work to promote this in
2 the State. As the depression campaign, it would be a
3 big undertaking, but the bang would just increase
4 exponentially.

5 Mr. Alexander: I know that we've gone to
6 the staff person at regional, and we need the
7 communication.

8 Chairperson Hyde: That's a great idea,
9 using the regional person. I have a feeling we're
10 going to put a lot on that person's shoulders, but
11 that's a great idea.

12 Okay, sorry I had to miss some of that, but
13 it was a good call, the National Drug Strategy
14 upstairs, so you'll hear about that a little bit
15 later.

16 We're on to Health Information and
17 Technology.

18 Thanks, Mark.

19 Mr. Weber: Thanks, I appreciate the
20 opportunity.

21 Chairperson Hyde: Health Information
22 Technology and that will be Westley Clark, that's on

1 page 9 of the Fact Sheet, down at the bottom, and it's
2 on page -- slide number 20 on the Power Point.

3 PRESENTATION OF H. WESTLEY CLARK, M.D.,
4 J.D., CAS, FASAM, DIRECTOR, SAMHSA'S CENTER FOR
5 SUBSTANCE ABUSE TREATMENT

6 Dr. Clark: This is an important topic, as
7 you get through your material, and as the lead I'm
8 working with the team of individuals from across the
9 Agency. We have representatives from all of the
10 sections and all of the Centers.

11 This question of why health IT is almost
12 rhetorical at this point, because we know that there's
13 a tremendous emphasis on the use of health IT and it's
14 inextricably tied, now, to healthcare reform. As it
15 was articulated, the potential to prevent medical
16 errors, increase the efficiency of healthcare and
17 reduce unnecessary healthcare costs, reduce
18 administrative inefficiencies, decrease paperwork,
19 expand access to affordable care and improve
20 population health.

21 Health IT, it was conceptualized as
22 increasing access for treatment, also, for rural

1 communities isolated and lack access to comprehensive,
2 high-quality healthcare. As I mentioned, this is
3 along the New Health Insurance Reform law which
4 requires implementation of uniform standards for
5 electronic exchange of health information by 2013.

6 The SAMHSA strategic initiative is to ensure
7 the behavioral health provider network, including
8 prevention specialists and consumer providers, fully
9 participate with the general delivery system in the
10 adoption of appropriate health information technology.

11 We have three basic goals, which of course
12 change. We should be integrating all SAMHSA grantee
13 performance data into one reporting system that meets
14 the standards set by the ONC, we should integrate
15 State and county-level specialty behavioral health
16 treatment and prevention systems into larger systems,
17 and evolve and complete development of integrated
18 security and privacy standards by ONC, based on
19 behavioral health requirements.

20 The Office of National Coordinator of
21 Health Information Technology takes the leads and so
22 we are working with ONC and really want to stress that

1 they have the lead, not only for the Department, but
2 for the Administration. And David Blumenthal, we're
3 working with, and we had a constituents meeting on
4 April 15th, we had approximately 70 attendees from
5 behavioral health provider organizations, State
6 representatives, behavioral health advocacy
7 organizations and private sector companies, among
8 others. We had representatives from the Office of the
9 National Coordinator, the Center for Medicare and
10 Medicaid Services and the HHS Office of the Assistant
11 Secretary for Planning and Evaluation.

12 We talked about Federal information
13 technology architecture, meaningful use, and I want to
14 dwell on this construct -- the second bullet,
15 meaningful use, data, requirements, system upgrades,
16 integration, incentives, and eligible providers --
17 those of you who are physicians, who work for
18 hospitals, will probably have heard by now that there
19 are incentives under the High Tech Act for the
20 adoption of electronic health information systems, the
21 census will come online next year -- a slightly
22 differing construct under Medicare and Medicaid, but

1 fundamentally under Medicare through physician, you're
2 eligible and if you're a hospital, you're eligible to
3 receive incentives. It's up to over a four-year
4 period with \$43,000 under Medicaid if you're a
5 physician, a dentist, a chiropractor, a nurse
6 practitioner, or a physician assistant. In certain
7 circumstances, you're eligible for Medicaid incentives
8 to adopt the technologies of up to \$63,000.

9 One of the things that was articulated is
10 that, at least at this juncture in time, meaningful
11 use won't include community mental health centers,
12 substance abuse treatment programs and prevention
13 specialists. And there is a bill that was introduced
14 by Representative Kennedy that will attempt to correct
15 that. Of course, we'll have to wait and see what
16 happens to that bill, but under the current construct,
17 most behavioral health practitioners are not eligible.
18 So, if you're a psychologist, social worker, MMT or
19 licensed professional counselor or substance abuse
20 counselor, under the current construct you're not
21 eligible for these incentives. These incentives are
22 eligible professional-driven, and they're also

1 attached to facilities like hospitals or critical care
2 units, critical care facilities.

3 We talked about an evolving toolkit for
4 long-term care and behavioral health and, of course,
5 there are privacy considerations in health IT.
6 Principally, we talk about Part 2, but it's not just
7 going to CFR Part 2. And my interactions with people
8 from the mental health community -- I was reminded
9 there was a traditional of confidentiality and
10 privacy, as I was reminded by psychiatrists, I kept
11 that in mind. So, while CFR Part 2 is a Federal
12 standard, there are wide variations in jurisdictional
13 approaches to State jurisdictional approaches to
14 privacy.

15 So, these issues were discussed. According
16 to CFR, Part 2 has some flexibility that need to be
17 exploited that people have forgotten, but there are a
18 host of issues associated with it.

19 The provisions in ARRA that promote the
20 adoption of interoperable health information
21 technology and promote the meaningful use of health
22 information technology are substantial. There's 20-

1 to \$40 billion associated with that, and that is going
2 to essentially the primary care delivery system.
3 Behavioral health is not considered essential to that
4 at this juncture and we, of course, being concerned
5 about behavioral health dispute that, but we have to
6 work within the parameters of the law.

7 Fortunately, we've met with David Blumenthal
8 who is very much interested in working with us to make
9 sure that behavioral health has some role as things
10 evolve. What I'm going to do is point out that the
11 HITECH Act provides assistance and technical support
12 to providers to enable coordination and alignment
13 within and among States, establish connectivity to the
14 public health community in case of emergencies, and
15 ensure the workforce is properly trained to be
16 meaningful users of electronic health records. And
17 this is not just electronic medical records, one of
18 the cornerstones of EHR is the interoperability across
19 platforms, across settings, not simply to have
20 electronic medical records.

21 We looked at the literature and talked to
22 constituent groups, and we note that the behavioral

1 health community is often paper-and-pencil, but in
2 some cases does have electronic medical records, but
3 not necessarily a direction which I'm comfortable
4 with.

5 So, I thought I would survey the HITECH
6 programs, because one of the things that is critical
7 to us is, we need to know what is in the HITECH Act
8 and what it means to local jurisdictions, so I'm going
9 to cover those issues.

10 In the 2011 budget -- because there's a
11 proposal for \$4 million for ONC to help develop
12 standards, and SAMHSA will be working with ONC to help
13 develop these standards that are applicable -- but \$4
14 million compared to 20- to \$40 billion is, shall we
15 say, kind of a decimal point.

16 But, there are a range of programs that the
17 HITECH Act has provided funds for and that we should
18 be interested in. I'll start off with the State
19 Health Information Exchanges, this was already
20 mentioned briefly. This is a grant program to support
21 States, so State-designated entities to establish
22 health information exchange capability among

1 healthcare providers and hospitals in their
2 jurisdiction.

3 In March, some 56 States and eligible
4 territories qualified as State-designated entities
5 received awards where these were responsible for
6 increasing connectivity and enabling patient-centric
7 information flow to improve the quality and efficiency
8 of care.

9 Now, here are some of the entities and
10 awardees. With regard to jurisdictions, Arizona has
11 gotten one of these -- Kate, are you working with the
12 Arizona agency? Very good. And Arkansas got one, and
13 Georgia got one -- the young man from Georgia --
14 Arturo, are you working with New Mexico?

15 Ms. Wainscott: Georgia Community Health.

16 Dr. Clark: You're working with Georgia HIE?

17 Ms. Wainscott: Not working with them, I'm
18 on their Advisory Committee. They're doing all of the
19 work.

20 Dr. Clark: Ed, Massachusetts has one,
21 you're not involved? New York got one, and North
22 Carolina, Flo?

1 Ms. Stein: They are in our building.

2 [Laughter.]

3 Dr. Clark: This is exactly what we're
4 concerned about, and we use that kind of model, I
5 didn't know your specific experience. But, we often
6 state, you're in the same building. They've got these
7 resources, they're influencing the whole delivery
8 system, and you're not talking? So, we want you to do
9 more than be in the same building. We want you to
10 start talking, because even though their principle
11 focus is on the timely provision of care, the
12 behavioral health care does cost the State a lot of
13 money, and do we need to make sure -- since one of the
14 purposes of this is to increase access to information
15 and reduce the burden on the State budget, but also
16 increase patient safety.

17 Oregon -- since they have so many
18 representatives from Oregon present on the Council,
19 are you familiar with the Health Information Exchange
20 in Oregon?

21 Dr. Rosen: I don't work directly with them.

22 Dr. Clark: And then Virginia?

1 Mr. Braunstein: My IT Director is on that
2 group.

3 Dr. Clark: But, the key issue is this is
4 initially a planning process, so when we talk about
5 information exchange, what is it that we need? And
6 also -- even though we're not deemed, if you will,
7 meaningful users are eligible professionals. The fact
8 is, our delivery system has to be an integral part.
9 If we're talking about integrated care, it has to be
10 an integral part of the paradigm, which means, they
11 need to understand some of our issues, and we need to
12 understand some of their issues.

13 So, this is an important -- that's why we
14 singled out these awardees, because one of the things
15 that we've encountered is that people often don't know
16 what is going on, and as Flo points out, in the same
17 building.

18 It's easier, I guess, the argument is,
19 "Well, you're across town or in a different city,"
20 because some States have offices all over the place.
21 But the key issue is, we need to know what's going on,
22 we need to be in contact, the Governor is often in

1 charge of all of this, anyway. So, the Governor is
2 paying a lot of money for mental health, behavioral
3 health care, and she will want to know, "Gee, how can
4 I make this more efficient, how can I deal with these
5 issues and minimize the problems?"

6 Another program is the Health Information
7 Technology Extension Program. It's a grant program to
8 establish health information technology regional
9 extension centers to offer technical assistance,
10 guidance and information on best practices to support
11 and accelerate healthcare providers' efforts to become
12 meaningful users of EHRs. Funds were awarded to 60
13 non-profit institutions and organizations to establish
14 these HITREPs or Health Information Technology
15 Resource Extension Programs, so here's a list of some
16 of the awardees. So, we get back to the same
17 question. Now, the HIEs, Health Information Exchange,
18 and Regional Extension Centers, which are supposed to
19 be working -- and again, their primary focus is on
20 primary care, but there should be a dialogue about
21 behavioral health care.

22 So, I would ask the same question -- is

1 there any information going to these entities on this
2 list? And remember, there are more than that, but
3 this meets the configuration of the Council. So, the
4 Center for Innovative Technology for Virginia, is your
5 IT person talking to them about their new grant?
6 Remember, the grants have just been awarded in the
7 past couple of months, and it takes time for people to
8 ramp up, but once they get going, if you haven't been
9 at the table, they're going to say, "Who are you?"

10 So, now's the time for entities to be
11 introducing themselves, and this is something that
12 we're trying to promote, to educate the providers'
13 association, and so they're aware that there are these
14 resources. And even though the resources are
15 principally targeted to meaningful users, we believe
16 that we would be -- we're of concern. And if the law
17 of the Kennedy bill succeeds, we will be subsumed
18 under that, and we want to make sure that people are
19 aware, this is all public information. They will go
20 from health information exchanges, regional extension
21 centers to curriculum development center programs --
22 these are the programs to provide grants to

1 institutions of higher education or consortia thereof
2 to support health information technology curriculum
3 development. It's a component of the health IT
4 workforce program, \$10 million in grants were awarded
5 to five domestic institutions of higher education to
6 develop curriculum and instructional materials to
7 enhance workforce training programs primarily at the
8 community college level. It's an important point.

9 And awards were given to Oregon, since it's
10 got so many representatives and they also had the
11 national training and dissemination center, Colombia
12 University and Duke University. Again, the question
13 is, are we aware of these things, are we talking to
14 them because, indeed, and the questions would be,
15 well, we have some unique issues that we want to work
16 for us that provides us with technical assistance to
17 be aware of some of our unique issues, and there also
18 represents training opportunities when you develop
19 software for the behavioral health system.

20 Remember, this is not going to -- this
21 doesn't have to be the same software, it just has to
22 be interoperable. And ONC is probably getting

1 standards, they've got an interim final rule they
2 published, and CMS has had a Notice of Proposed
3 Rulemaking, and they're finalizing that. So, the
4 whole issue of meaningful use standards associated
5 with meaningful use and eligible professions and
6 incentives, those things are being hammered out now.
7 And when these things mature, then we're going to have
8 these issues -- community college consortia to educate
9 health information technology professionals in grant
10 programs. It's a grant program that seeks to rapidly
11 create health IT education and training programs in
12 community colleges or expand existing programs.

13 In April, an estimated \$36 million in
14 cooperative agreements to five regional recipients
15 were awarded to establish a multi-institutional
16 consortium within each designated region, and among
17 awardees, North Carolina Pitt Community College -- you
18 know about Pitt --

19 Ms. Stein: You're really getting down
20 there.

21 [Laughter.]

22 Dr. Clark: And Tidewater Community College.

1 Why is that important? Because what they're trying to
2 do is make sure you've got technicians readily
3 available to pitch in and work with you. You've got
4 to have a community-based organization to say, "Okay,
5 I don't need to hire a Ph.D. from XYZ University to
6 help us with our issues, somebody with some technical
7 training from a community college -- and,
8 incidentally, who may also represent a workforce
9 opportunity for the people who have the skills to do
10 work with technology and computers and stuff," so we
11 should be thinking of this for individuals who are
12 interested in behavioral health technology.

13 A program of assistance for university-based
14 training, it's a grant program that has rapidly
15 increased the availability of individuals qualified to
16 serve in specific health information technology
17 professional roles requiring university-level
18 training. And also this is a compartment of the
19 health IT workforce. In April, grants were awarded to
20 nine colleges and universities to recruit selected
21 administrators, student financial assistance supported
22 under grant.

1 The roles targeted by the program are
2 clinical public health leaders, health information
3 management and exchange specialists, health
4 information privacy and security specialists, research
5 and development scientists, programmers and software
6 engineers and health IT subspecialists. Obviously,
7 this is a high level from the community college, but
8 these are some of the awardees. And again,
9 fortunately Pam has chosen a council with
10 representatives from, shall we say, a high tech
11 environment.

12 Now, the question is, are these council
13 members actually hooked up, as it were, are you
14 engaged, are you plugged in? So, we want to make sure
15 people are aware of these things, because part of our
16 respective efforts is to make sure that they'll be
17 linked with these strategies so we can benefit the
18 behavioral health community.

19 If a psychiatrist or a nurse practitioner --
20 we talked about integrated care, and you are not
21 engaged -- because some psychiatrist said, and we've
22 talked to psychiatrists, "Well, gee, I don't see that

1 the clients, they don't have enough information," so
2 we want to make sure, then, there's competency exams
3 for individuals with non-degree training. It's a
4 grant program, Northern Virginia Community College was
5 awarded \$6 million in a single, two-year cooperative
6 agreement.

7 Then there's a strategic health information
8 and advanced research project, which is a grant
9 program to fund research focused on achieving
10 breakthrough advances, again, more sophisticated but
11 target -- Harvard University has been awarded one of
12 these grants. So, anybody from Boston, you could hook
13 up with Harvard on the SHARP program. So, we are
14 looking to the future to participate with ONC. We
15 have staff down there for their technical review for
16 HIEs, in fact, we just lost a staff person, ONC did
17 such a great job of mesmerizing one of our staff
18 persons, he jumped ship. That's okay, he's still
19 working on behavioral health issues. We want to make
20 information sharing tools available for clients, then,
21 more useful, convenient and trustworthy. In Lincoln
22 we use personal leave records, compile State agencies

1 to monitor and to reward performance of safety net
2 behavioral health providers and clients, essentially
3 working with the behavioral health community to
4 facilitate regional information exchanges and
5 facilitating the appropriate things between primary
6 care and behavioral health care, keeping in mind that
7 some of our unique issues are a barrier to health
8 information exchange or barrier to our being a part of
9 the new design. And as John O'Brien pointed out, you
10 need to be able to build, you need to be able to
11 exchange information on health information with
12 healthcare reform. If we can't do that, then we're at
13 a disadvantage, we put our clients at a disadvantage
14 and we don't want to do that.

15 So, I think that's that end of that
16 presentation. And I guess we should talk.

17 Chairperson Hyde: Yes, thank you, Wes.

18 I think Wes made the point, it's all out
19 there, all around us, yet we haven't figured out what
20 to do with it.

21 We'll start with George.

22 Mr. Braunstein: Well, since Virginia was

1 mentioned, only Oregon had more mentions, and North
2 Carolina. I've got one of the things that I think
3 would be useful at some point and I don't know if it
4 will come out of the work that you're referencing or
5 come out of SAMHSA itself would be the fact that there
6 are initiatives going on aside from those funded by
7 Federal Government.

8 I'm on the Board of a Regional Health
9 Information Organization, HRIO, that has been working
10 to integrate and work together on having our
11 electronic records talk to each other and begin to get
12 the availability of people who are receiving services
13 have greater access to their own health records.
14 We're working among the members of that, we're working
15 those closely with a university that wasn't mentioned
16 on there, George Mason University, who's doing a lot
17 of work with us, on helping us develop our plans for
18 purchasing new software for our agency.

19 So, there are some major initiatives, and
20 they're large initiatives going on. This particular
21 one, this Northern Virginia HRIO includes Inova
22 Healthcare in Northern Virginia, which has private

1 psychiatric as well as medical services and our agency
2 and a number of universities including Northern
3 Virginia Community College.

4 So, in essence, I suggest that, at some
5 point, there be kind of an outreach to see what major
6 initiatives are going on out there, because there are
7 things we can probably learn from each other.

8 Dr. Clark: One of the things we want to
9 stress, and we've got staff working, again, with ONC,
10 is that whatever software packages you buy, whatever
11 you use, that they're in alignment with the
12 expectation of CMS an ONC. People have bought
13 software in the past, it has not been certified
14 software, the standards have not been recognized and
15 then wind up with expensive software they're going to
16 have to replace. So, that's my only caveat is, pay
17 close attention to what is being promulgated by ONC
18 and we certainly will be happy to work with you,
19 because indeed we are very much interested.

20 I was just up in Rochester, Kim Sallyer and
21 I visited a program among multiple providers and
22 working with their HRIO and their, I guess, legacy

1 health systems agency and the whole purpose is to make
2 sure that we don't go so far ahead that we wind up far
3 behind. Because once everybody invests in it, then
4 their fingers are going to get singed if we're not in
5 alignment.

6 So, again, Pam has very appropriately
7 insisted that we follow the leads and follow what ONC
8 is doing, so we can help facilitate the best advice
9 along -- if the Kennedy bill passes, behavioral health
10 will be more central to the dialogue. Not that we're
11 unimportant -- we're very important, but with the
12 existing resources, we're not the principal entities
13 targeted.

14 Chairperson Hyde: We're also a little bit
15 concerned, some of the vendors now entering this field
16 -- especially for behavioral health -- are trying to
17 get into the vacuum that is there for not having
18 national standards. So, there will be a health piece
19 of this, and we're a little bit worried that then once
20 that happens and vendors get their stake in their
21 system, that it will be a lot harder for us or anybody
22 else, ONC or anybody else to try to set what those

1 standards are, given that we have sort of things on
2 top of that we have to deal with in terms of sharing
3 information, so we're a little bit concerned about
4 that. And trying to get ahead of this one is one of
5 Westley's challenges. It's hard to say "ours."

6 Dr. Clark: Our challenge.

7 [Laughter.]

8 Ms. Aurelius: Arizona had a \$69 million
9 Medicaid infrastructure grant with which we created a
10 health information exchange, and shockingly and
11 disappointingly one of the biggest barriers were the
12 issues around consent, and whether people opted in or
13 opted out of mental health information. So, I'm so
14 excited, I want to stand up and applaud, and "yay" you
15 for your enthusiasm for thinking about how we're going
16 to include behavioral health in there. We know in our
17 State, literally, we're killing people for lack of an
18 ability to share information. And yet it was,
19 frankly, the mental health community that said, "Oh,
20 no, you can't put the data in there." And we said,
21 "Well, you know, if it's an emergency room and
22 somebody is there, we really want them to know what's

1 going on." So, that's going to be a really important
2 role for SAMHSA is to help the behavioral community
3 understand that it --

4 Dr. Clark: We're working on some Frequently
5 Asked Questions for substance abuse and HIEs, but we
6 also have to deal with mental health. Both
7 communities have a unique vision of privacy and
8 confidentiality that we need to address.

9 Chairperson Hyde: Anything you all can help
10 us about with that, let me tell you the kind of help
11 we need. There's clearly a misunderstanding, and
12 Kate, I think you were going there, for clarifying --
13 and that's what we're trying to do, is clarify what
14 the law does allow you to do. Because there's a lot
15 of, "Well, I can't share anything," "Well, yes, you
16 can. If you follow the rules, you can." It just gets
17 a little more complicated. But, part of what was said
18 in the Q&A is just trying to clarify what you can do.

19 And, secondly, where are there things that
20 you see really is a true barrier that the law causes?
21 Because we've been asked to -- and we've not yet made
22 a decision about -- whether or not we have taken that

1 legal regulatory barrier is actually big enough that
2 we need to go in and open up that can of worms.
3 Because you can imagine, if we open that can of worms,
4 so we're trying to figure out whether clarification is
5 enough or whether there's some way around this. So,
6 input would be helpful about that.

7 Stephanie? And then Marvin, next. And then
8 Stephanie.

9 Mr. Alexander: I wonder about integrating
10 systems, particularly foster care and the information
11 that they collect. I know in Arkansas there's a
12 system called CRIS, which is the child reporting
13 system for people in foster care at schools. They
14 have a school-wide information system, the juvenile
15 justice -- it depends on what county you're in -- they
16 have their own system. So, I wonder, you're talking
17 about health, and juvenile justice settings become de
18 facto kind of health providers, foster care system is
19 a de factor mental health provider. And the concern
20 for me is, when I have a kid that I'm providing
21 service to and they're in foster care, and then a
22 month later they are sent to a different part of the

1 State. We don't know where they're at, because
2 they're in foster care, but we know they have some
3 significant issues.

4 As far as integrating information for
5 children, is that part -- was there any discussion? I
6 know some of those meetings have already happened. Is
7 there, I mean, those are definitely help-determining
8 agencies when we talk about kids, were there any
9 conversations? Or were we just simply talking primary
10 and mental health?

11 Dr. Clark: This is still an evolutionary
12 construct. So, no discussion is off the table. In
13 fact, we've got one model that we've put on the table
14 for discussion that would allow an exchange of
15 information from other interested parties, like
16 criminal justice, child welfare, et cetera, and at the
17 same time, protecting privacy of the individual. So,
18 we recognize from a behavioral health point of view
19 that there's a large array of vested, interested
20 parties that might want to exchange information, but
21 we wanted to make sure we don't prejudice an
22 individual's situation with that.

1 So, again, the debate and the discussion is
2 ongoing and still evolutionary. And so we haven't
3 excluded it.

4 Mr. Alexander: That discussion at SAMHSA is
5 that something that, again, with the statute, I know
6 everybody's doing their own thing.

7 Dr. Clark: No, this Administration is
8 committed to collaboration and coordination and non-
9 duplication of effort and so if, in fact, we've got
10 unique variables --

11 Chairperson Hyde: Marvin, you're raising a
12 really good point and sometimes those other systems
13 provide self-contained systems, so within their system
14 they can talk to each other. And then the issue is
15 both a technical one -- can it, as Westley said, is it
16 interoperable, can it electronically talk to another
17 system? That's one issue. And then there's all the
18 legalities of, can it talk to the other system? And
19 so, there are two different issues, here, a technical
20 one and a legal one.

21 It's a great question. The Juvenile Justice
22 Task Force led by the Attorney General was talking

1 about this the last meeting we were on, and I'm on
2 that Task Force by statute, which is kind of odd,
3 because the Secretary is also on it, so we're both on
4 it. And the issue came up of all of the barriers of
5 talking about kids' needs across school, juvenile
6 justice and mental health systems. And half of the
7 room was going ape about, "We've got to make this
8 happen and it takes Congress to do it," and let's go
9 there, and the other half were saying, "Whoa, whoa,
10 whoa, before we start sending kids' information around
11 right and left, what's that going to do to their
12 future?" So, it is a huge issue.

13 Mr. Alexander: Well, with technology we can
14 restrict access, there are ways. We can always
15 identify barriers.

16 Chairperson Hyde: The issue is, it is just
17 -- it's both technological, it's not an easy question.

18 Stephanie, next.

19 Dr. LeMelle: I mentioned this earlier when
20 you were out of the room, but it was on your slide,
21 which is the communication between clinicians and
22 clients and clients and clinicians. And again, I

1 think when we're talking about communication across
2 systems, I think it's sort of a different level, but
3 when you're talking about, on a personal level,
4 communications between a client and a clinician, it is
5 tricky. And I wonder if you guys have spent any
6 particular time talking about the policy or
7 regulations about that type of communication, and in
8 particular, I'm thinking about using Facebook, using
9 email, using text messaging, Skype, all of these
10 electronic means, not necessarily in the electronic
11 medical record but in communication, let's say, if a
12 client communicates with a technician by some means.
13 Should that, then, be part of the electronic medical
14 record? Do you need to put that into the record? Has
15 that sort of discussion happened?

16 Chairperson Hyde: That's a great question,
17 do you know the answer?

18 Dr. Clark: No, but we have members of our
19 IT team in the audience, and we're taking copious
20 notes. So, it represents an opportunity to establish
21 that. In fact, just yesterday we met with Dave
22 Gustafson who is in the process of improvements, and

1 it was showing a communication/recovery oriented Palm
2 Pilot-like type gadget that can be used for
3 individuals to help facilitate recovery and to respond
4 to crisis, and it can be uploaded into the chart. So,
5 we have to distinguish that.

6 I also know there are others in the
7 behavioral health community looking at the issue of
8 the ethics of using some of these technologies. But,
9 as was pointed out, we shouldn't allow tradition to
10 encumber us, to keep us from exploiting the process of
11 technology, but we shouldn't also use technology to
12 look at some of the core issues that we have.

13 So, I think we can mediate both, so we will
14 keep those questions in mind at what -- because we'll
15 also have to share, at what point is a casual
16 conversation a formal conversation? And we don't
17 really want -- and I'm a lawyer, among other things --
18 so we don't really want the legal process to answer
19 that question for you. We would like to have an
20 informed, ethical discussion about the process.

21 Dr. LeMelle: And I think that's part of the
22 process, at least it's been raised in our institution,

1 is that our institution considers email a legal
2 document.

3 Dr. Clark: It is a legal document, yes.

4 Dr. LeMelle: If someone writes to you on
5 email, "I'm suicidal," and they send it at four in the
6 morning and you don't read your emails until six in
7 the morning, I mean, there is this whole -- and should
8 that actually, should that email actually be part of
9 the chart?

10 Mr. Alexander: Text messages become legal,
11 as well.

12 Chairperson Hyde: Flo, you're next.

13 Ms. Stein: I was just thinking, we had a
14 project to try to do more with advanced directives for
15 a long time and we never can make it happen. But
16 electronic health records could allow it to happen
17 with a provision for this kind of sharing, where the
18 consumer would put their directive in the health
19 record, then it would be available.

20 Ms. Cushing: Just quickly, this isn't new
21 news to any of you, but so often a case of a consumer
22 or patient is very willing to have the information

1 shared, it's the provider who feels reluctant and is
2 not quite sure what they're allowed to do. So,
3 perhaps some very extensive training is required as
4 part of either a funding mechanism or some other way
5 to help the provider along or give them a sense of,
6 "This is okay, we can do A, B and C, because it often
7 isn't the patient."

8 Chairperson Hyde: I've got Don next.

9 Dr. Rosen: So we have an electronic medical
10 record system which is fairly sophisticated and we
11 have a type of privileged communication that patients
12 can access through EPIC called PIEchart, and they can
13 email their doctor and it's nondiscoverable. And I
14 tell all of my patients that, and some of them use it
15 but many of them don't. They would prefer to email
16 me. Everybody emails me, not through the fact that
17 there are potential legal consequences for that, and
18 it's not their confidentiality I'm worried about, I
19 don't care if they violate it, it's their information.
20 It's what I respond to. And so I feel quite stuck
21 with that, in part, for some of the reasons that you
22 mentioned. So, part of what we have struggled with

1 is, there's some information I want emergency room
2 people to access -- meds, allergies, things like that.
3 There is information I want to be able to think about
4 before I decide whether or not I want them to access
5 it. And there's some things I never want them to be
6 able to access and so we have various degrees of
7 encryption that are designated by the provider so that
8 there's not a one-shoe-fits-all approach.

9 Dr. Clark: That's very important, and we
10 start from HIPAA, there would be notes, different --
11 treated differently than regular records. And these
12 phase one of meaningful use. They're working in what
13 is called the CCD Continuity Care Document, which only
14 includes things like medication, diagnosis, and is
15 limited in what it contains.

16 What we're trying to do is stimulate the
17 behavioral health community to address some of the
18 very questions we're hearing here, so that when we go
19 to the table we can air those issues out and see if we
20 can use technology to address, either to encryption or
21 other means and mechanisms, so that everyone is
22 comfortable and the patient gets the best care.

1 Chairperson Hyde: Arturo? This will
2 probably be the last comment.

3 Mr. Gonzales: When we talk about health
4 information technology, one of the things that came
5 out at the American Telehealth Association national
6 meeting last year and will come up again this year is
7 that we often forget that Telehealth is a part of
8 information technology. It's not just in electronic
9 medical records, and there's a need to place some
10 focus and energy on how we're going to deal with this
11 Telehealth issue with regards to protocols for how
12 services can be delivered in rural areas, behavioral
13 health and whatever. Who needs to be in the room,
14 what kind of confidentiality, what kind of encryption,
15 and what gets in the note or doesn't get in the note.
16 And then the other piece is the billing for it -- who
17 gets paid for it. The host site, the psychiatrist
18 off-site, how is that going to work? There's a whole
19 area for whatever help you could bring to the
20 discussion would be very, very helpful to give us
21 guidance.

22 Dr. Clark: We will include that. As Pam

1 pointed out, we met with Mary Wakefield's group,
2 they're raising the issue of Telehealth also, it's not
3 just peculiar to behavioral health, and so your points
4 are well-taken. And especially as we move into the
5 more integrated comprehensive systems, instead of the
6 sort of stand-alone projects.

7 Chairperson Hyde: Okay, so I think Westley
8 alluded to this, but he's got an M.D., a J.D., a
9 Ph.D., I think before he's done he's going to have
10 I.T.D. So, thanks, Westley, this was terrific
11 conversation.

12 We're going to let you have a 15-minute
13 break, but once again, we will start right at a
14 quarter till.

15 [Recess.]

16 Chairperson Hyde: Our next issue is --
17 Westley, again on behavioral health workforce.

18 Dr. Clark: Another issue of critical
19 interest to all assembled is the notion that we need a
20 behavioral health workforce. Looking at our 2000
21 data, we estimate there are 22.2 million people who
22 classify with substance abuse or start off with

1 substance abuse, but only 4.8 million received
2 treatment in 2008, so we've got 22 million meeting
3 criteria for a specialty treatment, but only 4.8
4 million. There's an estimated 9.8 million adults with
5 serious mental illness, but only 5.7 million of them
6 used mental health services in 2008. When we look at
7 substance abuse, the primary reason reported for not
8 receiving substance abuse treatment by those who
9 sought it was a lack of coverage or finances. And the
10 primary reason for not receiving mental health
11 services was inability to afford cost and another 14
12 percent said health insurance didn't cover all or a
13 part of the treatment. So money has been an issue in
14 the past.

15 We recognize though the healthcare reform
16 has been dealing with the issue. As pointed out, 32
17 million are expected to gain access to health
18 insurance reform. Now, we did a curbside calculation
19 based on estimated one percent of the people who are
20 the waiting list. We figured there would be 87,000
21 people with substance abuse who previous sought
22 treatment but didn't get it because of no insurance or

1 inability to pay, and as many 2 million new mental
2 health clients. John's portrayed the calculation,
3 he's more adept at it because he's totally immersed in
4 it in terms of 24/7 I think. He estimated two to four
5 million, but the fact is there will be more people as
6 a percentage than with the mental health services,
7 with the help in mental health insurance. This could
8 open the flood gates to 20 million people who need
9 substance treatment, but don't recognize that need,
10 5.1 million who need it but did not receive mental
11 health services in the past. That's a key issue, all
12 of this unmet need out there. Some of it's
13 facilitated by lack of insurance and some it is
14 facilitated by denial.

15 But with a delivery system more attune to
16 picking up symptoms or teachable moments, then we will
17 have more people who could be referred to specialty
18 care or who will need some specific intervention in
19 the primary care setting.

20 Before we had a situation with empty chairs,
21 if you increase the demand, the question is will you
22 have enough providers or not enough chairs. Fifty-

1 five percent of the U.S. counties have no practicing
2 psychiatrist, psychologist, or social workers, and all
3 of these counties are rural. There's a projected need
4 by 2020 for 12,624 child and adolescent psychologist,
5 but a projected supply of 8,300. The U.S. Census
6 Bureau by 2031, one in every five U.S. citizens will
7 be 65 or older, but only 700 practicing psychologists
8 view older adults as a principle population. This is
9 10-year old data, but the fact is that's increased
10 dramatically.

11 A recent study found 15 percent in front
12 line staff and directors of substance abuse disorder
13 treatment agencies in a single year, so not only do we
14 not have enough practitioners, we also have a problem
15 with low pay and turnover. And in short, the current
16 behavioral health workforce is understaffed today, and
17 if we do increase the demand, as Pam pointed out with
18 Mary Wakefield, and she said community health center
19 substance abuse centers will be able to refer people
20 to some place, the question is where. So we detect a
21 problem, can we refer?

22 So, our objective is to provide a

1 coordinated approach to address workforce development
2 issues effecting the behavioral health and general
3 health service delivery community to promote the
4 integration of service in training and use of
5 behavioral health screening, brief intervention, and
6 referral for treatment in primary care settings. So
7 we need people who are prepared.

8 Now initially, we're trying to take the
9 coordinator approach using CMHS's as technical
10 assistance center or CSAP's application prevention
11 technology and CSAP's addiction technology transfer
12 centers. We need to meet the needs of providers
13 operating in a more integrated environment, mediated
14 by healthcare reform, and facilitated by health
15 information technology.

16 So, we've a proposed initiative, goals to
17 increase the ability of the behavioral health workers
18 to adopt evidence-based practices, by developing and
19 delivering training across behavioral health
20 disciplines, to address behavioral health workforce
21 shortage by increasing the number of adequately
22 prepared peers and consumers and family members who

1 provide services based on a set of core competencies.
2 As this issue was raised, and we want to make sure
3 that what we're providing is responsible and
4 reasonable. We need to promote competency and
5 recovery oriented services during training of current
6 professionals across behavioral healthcare, and
7 improve the ability of primary care providers to
8 conduct behavioral health screening and brief
9 intervention and referral for treatment.

10 We had a behavioral health workforce
11 constituents meeting on April 26th. We had
12 approximately 60 people in attendance, including
13 behavioral health provider organizations, professional
14 guilds, medical societies, organizations representing
15 State authorities, consumer group representatives, and
16 private employers. We had presenters from HRSA, the
17 Health Resources Services Administration, the Centers
18 for Medicare and Medicaid Services, Faces and Voices
19 of Recovery, and the National Business Group on
20 Health.

21 The agenda included presentations and
22 dialogue with the stakeholders, and the topics

1 discussed, the opportunity presented by healthcare
2 reform, the role of peers, communities, and employers
3 in behavioral health workforce development, and then,
4 of course, primary care behavioral health integration
5 and implications for health professions.

6 The major issues that arose is the need to
7 prepare providers to operate in the new systems that
8 will be created by health insurance reform. Training
9 needed that included evidence-based practices, this is
10 a question that's been raised in multiple settings,
11 particularly in community health centers. What
12 evidence-based practices -- CMS is asking this, "Well
13 what are your evidence-based practices?" And this is
14 a question that John O'Brien encounters when he's
15 talking with his colleagues at CMS, which one should
16 we support, which one should we fund, understanding
17 recovery as a construct and co-occurring disorders.
18 Also an issue that's been raised at this meeting, and
19 then working with primary care providers so that we
20 can address these issues in settings and manners in
21 which they're comfortable. We need to address
22 disparities in rural and intercity areas.

1 And the issue of healthcare disparities is
2 an important one. Behavioral health workforce needs
3 to be more diverse and culturally competent.
4 Recruitment of workers is critical because of
5 anticipated increase in demand and the aging of the
6 workforce itself. Something that many people have
7 noted, that we have not made working in the behavioral
8 health arena as attractive as we need to, so that we
9 can get a replacement. We need succession planning,
10 not just in our non-profit organizations and our
11 bureaucracy, but also in our provider community.

12 Another issue is, in the constituents
13 meeting with SAMHSA, is we continue to work with
14 stockholders and other federal agencies to identify
15 gaps, to develop strategies, to address constituent
16 content of flat issues, to identify model and
17 innovative approaches on issues such as integration of
18 primary care, behavioral health, the use of
19 technology, something that served us here, both
20 telemedicine and other technological strategies and
21 guidelines promulgated associated with this. This has
22 been a very interesting discussion from the technology

1 point of view, but also as it moves into the workforce
2 issues and reimbursement strategies. Again, that
3 topic came up in previous discussions. Why would I do
4 this, et cetera, than support the adoption of
5 evidence-based practices through training and
6 technical assistance?

7 When we are -- in order to meet the goals,
8 we know that there's a paucity of trained qualified
9 behavioral healthcare personnel in rural and
10 underserved areas, how do we address that? The gaps
11 in access to behavioral healthcare workers and
12 services have largely been filled by self care, peer
13 support, and family care giving. Individuals with
14 mental health and addiction problems, along with their
15 families, should be recognized as part of the
16 workforce, and efforts should continue to develop
17 their capacity to care for themselves and each other
18 effectively. And, what gets us into a recovery motif,
19 which indeed we need to be able to exploit and we need
20 to be able to fund.

21 Diversity, increasing diversity -- I
22 mentioned that the behavioral health workforce

1 currently lacks diversity and often does not reflect
2 the populations being served. Efforts need to
3 continue focusing on recruiting minorities to enter
4 behavioral health, along with the general population.
5 The behavioral health workforce is aging, again that
6 notion of the aging workforce, developing leaders and
7 managers, and our three centers have leadership
8 training. We need to coordinate that since it's one
9 of the things on our table, our workforce initiative
10 needs to address the issue of middle management and
11 moving into upper management and equipping individuals
12 who are, shall we say, brave enough to become
13 managers. Some metaphorical hand-holding, so that
14 they feel comfortable with their role, because despite
15 the fact that some of us want to work forever, it just
16 doesn't happen. Other workforce development programs,
17 we've got workforce development initiatives associated
18 with our screening and brief intervention activity,
19 minority fellowship program -- Faye brought that to my
20 attention just a little while ago -- the National
21 Centers for Application of Prevention Technology, the
22 National Centers for Trauma Informed Care, Knowledge

1 Application Program is a workforce focus, and the
2 National Center for Trauma Informed Care.

3 Our medical residency is a program that we
4 should exploit. We have 17 grantees in medical
5 schools, hospitals, training. Initially it was for
6 physicians, but as we look at what they're doing,
7 they're not just including physicians, they're
8 including nurses and social workers, psychologists,
9 and others to establish SBIRT training as a component
10 of residency programs in a variety of disciplines,
11 including emergency medicine trauma, pediatrics,
12 family medicine surgery. And to make sure that when
13 we talk about substance abuse, if we talk about co-
14 occurring disorders, we're talking two people who have
15 some skills and not skills acquired five minutes
16 before you see the patient, or in some cases, five
17 minutes after.

18 To promote the adoption of SBIRT via wider
19 dissemination of SBIRT practices through this range of
20 practitioners and training must be expanded to include
21 mental health providers and other behavioral health
22 providers. And this concept of SBIRT is in the

1 healthcare reform bill. So, there is the expectation,
2 and you will also hear about this from Gil
3 Kerlikowske, because he's been a long proponent of
4 shifting the focus of mental health activity to
5 primary care.

6 This is the medical residency grantees, and
7 this doesn't overshadow some of the other activity,
8 but it does represent SAMHSA's movement into primary
9 care by training primary care providers. And bringing
10 them onboard so that they participate in the training
11 of primary care providers. And Oregon has a program -
12 - there's a program in Macon, GA, there's a program at
13 Children's Hospital in Boston. Sorry everybody else.

14 Mr. Gonzales: You know Dr. Clark, when I
15 see that map, what confuses me is training of
16 residents. If you look at that map, I don't see any
17 training of residents in the rural areas of this
18 country. I don't see any in New Mexico, I don't see
19 any in Arizona or Colorado or Utah. How are you going
20 to train residents for SBIRT in rural areas if you're
21 training them in Boston?

22 Dr. Clark: I agree, and indeed one of the

1 things that we're interested in, of course, is
2 continuous -- and remember these are fairly new. And,
3 we got support for this from ONDCP and moved forward.
4 And as we fine tune this objective, because again, we
5 will be working with HRSA on this issue, as Pam
6 pointed out. She met with Mary Wakefield and her
7 senior leadership, and we've got a commitment to come
8 together, but what we need to do is establish that
9 there is a willingness on the part of primary care to
10 explore this. Because again, you can't just show up
11 and say, "You guys have got to do this." Anybody who
12 has worked with organized medicine, there's a
13 tremendous amount of pushback when someone's got an
14 idea de jour, and they say, "Well, you guys should be
15 training this and this and this." Yeah, and continue
16 business as usual.

17 So, with these 17 programs, we're able to
18 establish that we in fact can change business as
19 usual. And what you're doing very appropriately is
20 identifying, okay, now that we have got a toe hold, we
21 need to move into other areas and address the issues
22 associated with other communities, and not just in the

1 Northeast or in California, although our Salinas
2 project is actually rural. And the University of
3 Missouri in Columbia is more rural, but what we want
4 to make sure is that the curriculum meets the needs of
5 rural communities, and we've got the tribal
6 communities that we have be able to deal with,
7 reservations. And we have other issues, that we need
8 to make sure that we're addressing these issues.

9 But the key point is that we've got
10 organized medicine to accept these modifications of
11 their training programs, and they've done so willingly
12 without arm twisting. And SAMHSA was able to pull
13 that off, and so it is not sufficient in the long-
14 term, but it is important to acknowledge that we were
15 able to -- have been able to make a difference in the
16 short term, and then we'll move forward with that.

17 Health insurance reform requires the
18 adoption of evidence-based practices by the behavioral
19 healthcare systems, people and primary care systems,
20 and people are now acknowledging that, so the
21 partnerships that Pam is forging -- we are finding
22 that people are willing to hear and listen. So there

1 are opportunities. And as has been pointed out, we
2 can't do everything, but we can work with other people
3 so that we can do a lot more than working by
4 ourselves.

5 The adoption of new skills requires that
6 training and clinical supervision and ongoing
7 monitoring to ensure fidelity to protocols. The pre-
8 service education must keep up with research findings
9 and utilize adult learning methods to impart the
10 knowledge and skills necessary to perform competently,
11 core competencies need to be developed, that will
12 provide the basis for the education of peer and non-
13 peer recovery support workers, and for staff working
14 with populations with co-occurring disorder.

15 So, we have a workgroup across centers that
16 are trying to address that. We don't have a major
17 budget, so our partnership with HRSA will become very
18 important. And our partnership with the Department of
19 Labor will become very important. HRSA has
20 scholarship programs, a loan forgiveness program, and
21 they're willing to talk. So, part of our objective is
22 to exploit that willingness in the service a workforce

1 that is more aware.

2 We don't currently collect behavioral
3 workforce data, we need to investigate how to gather
4 reliable and timely data regarding the behavioral
5 health workforce, and to analyze this data as the
6 basis for planning future programs and initiatives.

7 We've also established a relationship with
8 Job Corps to develop a pilot program to implement
9 SBIRT in the Job Corps sites. We've got a modest
10 SBIRT program with Juvenile Justice, so that we can
11 establish that you can screen for problems in the
12 Juvenile Justice system. An online recovery for this
13 thinking course is being developed and submitted for
14 field review, and SAMHSA and HRSA are working on an
15 interagency agreement for pilot training co-occurring
16 disorders in community health centers.

17 So HRSA has a lot of resources for workforce
18 development, and Pam's got a commitment from Mary
19 Wakefield to foster that. And so, that is one of the
20 things we're pursuing. And I think the meeting that
21 we had was a very good meeting, and showed a manifest
22 and willingness to help us develop strategies. We

1 have a TA center that is being developed, and that
2 will be explored.

3 So, there are multiple pathways, multiple
4 issues, some things -- some models include bringing
5 behavioral health workers into the primary care
6 setting. Other models have the primary care
7 practitioner equipped to do some of the assessments,
8 but the key issue is having the technology, i.e. the
9 IT and the workforce so that we can facilitate the
10 best care for the patient, and that includes peer and
11 recovery support.

12 So, we can see, as already been mentioned,
13 CMS has reimbursed for peer support in certain
14 situations where there is supervision, but we want to
15 make sure that when the professional delivery system,
16 whether it's peer support, when you're getting
17 reimbursed for services, those services have got to
18 meet certain standards, because the person receiving
19 the service has a reasonable expectation that whatever
20 it is they're going to get has a chance of working for
21 them, because no one promises 100 percent response,
22 but it still has to have a reasonable chance. We want

1 to make sure the provider, whether it's a peer
2 provider, recovery support provider, or someone with a
3 Master's degree and a license. They're bringing to
4 bear the best of the existing science can deliver, so
5 our workforce initiative is operating with that in
6 mind.

7 Thank you.

8 Chairperson Hyde: Great, thanks.

9 Wes, we have a few minutes to talk.

10 Ed?

11 Dr. Wang: Quick question. Has SAMHSA
12 looked at using the SBIRT model for mental health
13 screening and intervention?

14 Dr. Clark: I'm glad you mention that. We
15 have a project that we're working with CMHS on, that
16 we're about to put into play. So -- but one of the
17 things, and I think Pam points out, SBIRT is not a
18 Panacea for all that ails you, so we want to make that
19 clear. But what it represents is moving the locus for
20 identifying the issues from specialty care into
21 primary care, and then figuring out what the best
22 model for the primary care setting. Not all primary

1 care settings either have the temperament or the
2 resources to deal with full range of issues.

3 We do know that most antidepressants are
4 written by primary care practitioners, so we know that
5 they're dealing with a lot of issues, in terms of
6 depression and substance abuse. Community health
7 centers have only 700,000 clients. If you go to the
8 HRSA website, they have almost 700,000 clients who are
9 receiving care for depression, and almost 100,000
10 clients receiving care for substance abuse. So, it's
11 going on regardless, and so with the workforce
12 initiative, we're trying to facilitate that best
13 practices. But SBIRT is not a Panacea for all that
14 ails you, it's an important part of the comprehensive
15 delivery system.

16 Dr. Wang: Especially, I would say that what
17 you mentioned in terms of the community health
18 centers, because it really addresses a lot of
19 individuals and families that we don't have
20 opportunities to get in to a more regular system, but
21 with the community health centers.

22 Chairperson Hyde: Let's see, Stephanie

1 next.

2 Dr. LeMelle: In terms of the core
3 competencies, I think that one of the things we often
4 overlook is that behavioral healthcare workers are not
5 necessarily in how to work with peers and peer
6 counselors. And that we talk about competencies with
7 peer counselors, but I think you have to have
8 competencies for other behavioral health workers and
9 what to expect from peer counselors.

10 Dr. Clark: And that's a critical point, and
11 that is something that we need to make sure that we
12 adequately address. It is an issue that surfaced. We
13 do need to make sure that it is adequately addressed.

14 Chairperson Hyde: Don?

15 Dr. Rosen: Thank you for your presentation.
16 This is a hugely important topic on a number of
17 fronts. I work at an academic medical center and so
18 I'm constantly confronted with the problems in our new
19 graduates as well as graduate medical education. I'm
20 delighted to hear about the programs. I think that
21 goes a long way to making psychiatry an affordable
22 specialty to enter. And graduate medical education is

1 huge problem, and that is that there's every incentive
2 for medical centers to fund more lucrative
3 subspecialty training programs, and so that if there
4 are a certain number of stipends to disseminated to
5 various programs, primary care is not an outcome. The
6 medical school will make millions off some of the
7 student intervention radiology and break even on
8 someone training to enter psychiatry. So, looking at
9 the number of positions in psychiatry and internal
10 medicine and family medicine and pediatrics, those
11 numbers have stayed relatively stable, so that the
12 actual funding is about to get stashed away. There
13 are people applying for residency positions who will
14 not be able to get them because all the slots will be
15 taken. So it's not necessarily that more money needs
16 to float to graduate medical education, it needs to be
17 reallocated to highlight the need for primary care,
18 and disincentivize institutions from trying to use
19 trainings to meet their own bottom lines, rather than
20 to meet the healthcare needs of the country.

21 Chairperson Hyde: One of the things our
22 mental health and substance abuse centers said when we

1 met at the meeting that Wes mentioned, is their
2 ability to take in residents, as training sites are
3 really limited by the costs and what they can bill and
4 not bill for. And when they're so close on the margin
5 they can't do, which means if you don't get a resident
6 in that kind of a program they're not going to stay,
7 they're not going to stick.

8 That was a very interesting point. We're
9 sort of mulling about what to do with that because the
10 graduate medical education monies that come, for
11 example, through Medicaid has a tendency to go to
12 University-based programs or the bigger programs.

13 Dr. Rosen: And those universities take it
14 and allocate it to things that they need.

15 Chairperson Hyde: That's interesting.

16 Okay, Arturo Gonzales?

17 Mr. Gonzales: Thank you, Dr. Clark, for all
18 the information. Just a couple points, one on the
19 loan repayment issue. Where I think this could be
20 helpful, in terms of integrating primary care and
21 behavioral health, is if in your discussions with HRSA
22 there could be the allocation for loan repayment to

1 behavioral health workers. Right now the community
2 health centers look at the loan repayment, with
3 respect to their dentists and with respect to their
4 primary care providers, and they only have so many
5 slots and they don't want to give them up to get a
6 dentist or a medical care provider and yet there may
7 be a behavioral healthcare provider to work for that
8 integration, but they won't. If the behavioral health
9 provider has the loan repayment going to the community
10 health center, so if there was a loan repayment across
11 the board for behavioral health, that would be a good
12 part for integration.

13 The other piece, SBIRT has gone into mental
14 health. We've been screening for substance abuse and
15 for depression, clinical depression, and that has been
16 expanded. One of the things you mentioned that had me
17 a little bit confused was SAMHSA was being asked to
18 indicate to HRSA what were the best practices to be
19 used. It seemed to me that in the cohorts that were
20 funded on SBIRT, we were required to use evidence-
21 based best practices, so that I would think that
22 SAMHSA should be able to say to HRSA, "The best

1 practices are things like motivational interviewing,
2 craft, adolescent craft, CRA, et cetera." And those
3 are there to show the best practices.

4 Dr. Clark: Yes, what they're looking for is
5 the package deal that will help them collect data.
6 And so you're right, we just need to inventory a
7 configuration of strategies, and of them Plan A and
8 Plan B. We don't want to be flooded with, "You can
9 use the following 25 instruments," we may be
10 comfortable as behavioral health practitioners, but
11 they don't want to be flooded with endless options.

12 And we're finding that actually when we
13 start talking about harmonizing data -- Flo and I were
14 talking about that -- we need to be able to come up
15 with good information strategies so that people can
16 achieve the objective of helping the person that
17 presents.

18 Chairperson Hyde: I think two things about
19 HRSA, we just had this meeting with them last week,
20 and it was an excellent meeting. One thing they said
21 that I totally agree with, having been also on the
22 health side awhile, is that we ask our doctors to do a

1 lot of stuff these days. And the question is, what
2 can they say to the doc, "This is worth the extra 2
3 minutes, or 3 minutes, or 5 minutes, can I ask you to
4 do?" So, saying to them, "Here's 7 things you can
5 do," is too overwhelming, but being able to say,
6 "Here's one thing you can do in 2 minutes that will
7 really make a difference, or 3 minutes, or 5 minutes,"
8 and that's kind of the thing they're looking for.
9 They clearly are on the SBIRT, there's no question
10 about that. The discussion is sort of like, where you
11 went, is this worth it for other things?

12 Well, at some point, even if it's worth it
13 for 10 things, you can't do SBIRT for 10 things in
14 every visit, you just can't. So, the question is,
15 what gives you the best bang for the buck? So, you
16 have to start looking at the evidence, it's really
17 strong for alcohol, it may be less strong for illegal
18 drugs, it may be pretty good for depression, maybe
19 less strong for HIV. There's some issue about, can we
20 develop something for trauma, that sort of an SBIRT, I
21 mean, so those are the kinds of questions they're
22 asking for us. How could SAMHSA be helpful in that?

1 So, the good news is, they're asking us.

2 The second thing about HRSA is they've got
3 more money now for the National Health Service Corps
4 because of a combination of ARRA and the health reform
5 bill. So, literally, it used to be you had to stand
6 in line to get those applications in, now pretty much
7 anybody who comes in the door, they're going to have
8 money for. Which means, if we can get people to get
9 through that door for behavioral health, they're going
10 to get some money for the National Health Service
11 Corps slot, so there's lots of opportunities there,
12 and they're very open to how we can help them.

13 Okay, we have Marvin next.

14 Mr. Alexander: I wanted to comment on how
15 we've used SBIRT, not as a funding entity, but we've
16 just kind of used it in our juvenile detention center.
17 When a kid comes into the detention center, they're
18 screened using the Massachusetts Youth Screening form,
19 and there's a brief intervention. It used to be in
20 our professional, but because of funding there's not a
21 para-professional there, and there's a referral for
22 treatment. So, even beyond, kind of, the model, we

1 solved, kind of, the language in our program.

2 Chairperson Hyde: I think the other thing
3 that your comment raises and it is something we're
4 struggling with, and Westley mentioned it right at the
5 beginning of the workforce presentation, which is, so
6 we get everybody to do the screening, brief
7 intervention and referral, okay. If the brief
8 intervention works, terrific. When you get to the
9 referral part, who are you referring to? If we've
10 got, literally, 5 to 6 million more people and I,
11 frankly, think that's a low count, because I think
12 that's only talking about the people coming into
13 Medicaid. The other 16 million are going to have
14 additional issues and may be the ones that go into
15 primary care and get screened and get then told.

16 So, the number of that other 16 million, I
17 think, may really grow. We may be looking at 10
18 million new people knocking on the doors of mental
19 health agencies in some way or another, if we refer
20 that many people. I forget what the number was.

21 Westley, the other day, was it 30,000 people
22 who were referred out of a million? So, you can

1 extrapolate that. It does get to be an issue when you
2 get to the referral and treatment part, who's going to
3 take those individuals.

4 Flo was actually next.

5 Ms. Stein: I just wanted to make a pitch
6 for, I think, the community health centers and HRSA
7 are a great place. What I'm worried that we might do
8 is just have another half of a system, our
9 constituents have a hard time getting access to
10 primary care -- that is what they do really well,
11 asking them to do all of these things for healthcare
12 without partners. They need health educators, and
13 even in SBIRT, they need behavioral health
14 specialists. A doctor does the screening on the
15 primary issue -- pregnancy, HIV, whatever it is. But
16 somebody has to step in and do the behavioral
17 intervention. And we have some of our absolutely best
18 addiction treatment programs are in community health
19 centers, because we pay for the stuff they can't pay
20 for and they do the primary care that we could not pay
21 for. The two things together make a whole system that
22 can treat the person and their family.

1 Chairperson Hyde: You're absolutely right.
2 We actually talked about that. We said, "Look, if \$25
3 million new dollars," which is what's in the
4 President's budget for 2011, "if that gets in and goes
5 in the community health centers, either new ones or
6 existing ones, and they start trying to hire their own
7 people, all they're going to be doing is hiring them
8 away from the diversity, so there's not that many
9 extra people," so we did talk about, and you suddenly
10 know, it's CBH and SAS and some of the other provider
11 associations are working to try to do some
12 collaborations at the local level of community health
13 centers and specialty systems.

14 The fact is, though, that we know people are
15 going to walk into a primary care office with a
16 behavioral health issue not even realizing they have
17 that behavioral health issue and not willing to say
18 they have a behavioral health issue who would never
19 walk into a specialist if they didn't get there
20 through their primary. And so that's the trick, is
21 how you create those collaborations, absolutely.

22 Somebody told me, I can't remember if it was

1 here, or George or somebody else, that they had a
2 model -- was it you, Arturo? They had a model
3 arrangement, document, we might try to work with some
4 of the provider groups to put some of those kind of
5 model MOUs or whatever out there for people to use.
6 That's part of what I'm hearing back from providers,
7 because they don't know how to get started.

8 So, Arturo, you're next.

9 Mr. Gonzales: Well, Madame Chair, I think
10 the issue is, you are correct, what do you do after
11 you screen someone and you get a brief intervention?
12 Where are you going to refer them to? Well, it
13 depends on the model that's implemented. The model
14 you're talking about was a model we used in New
15 Mexico, whereby the behavioral health specialist is
16 located right in the primary care center, so the
17 referral is made to the behavioral health specialist
18 for the clinic and it's an issue with integration, not
19 collocation. And what do you tell the physicians how
20 to deal with this? Well, you're giving continuous
21 better care to your patients, you're going to have to
22 deal with this, anyway, you're not trained to deal

1 with these things in medical school, so why not refer
2 that to someone on site that is part of the team to be
3 able to work with you?

4 And it's expensive, but I think you're
5 right, the last thing you want is going and hiring
6 away from mental health centers for location
7 integration. And the template that Pam is referring
8 to, that we're looking at now, is a contract with the
9 FQAC for behavioral health services and the behavioral
10 health counselor, and the community health center
11 reimburses us who has the counselor at fair market
12 value so you can quantify how much it costs to put a
13 person there. And if it is in the scope of the work
14 of the FQAC, they can count this as part of the grant
15 and pay for those services, as well. So that may be
16 an enticement.

17 Chairperson Hyde: Cynthia?

18 Ms. Wainscott: There are essentially two
19 things that have to be better than they are now. One
20 is the organization of how we provide mental health
21 services and general medical care. And I think
22 medicine has given us a roadmap, they've said, "What

1 you need to do is integrate to the degree that you
2 can." Communicating is the first degree.

3 The second is the Memorandums of
4 Understanding and then you finally get to full
5 integration. I think we've gotten over, "This
6 absolutely won't work, they'll get all my money," I
7 mean, we really are past that, because the people are
8 demonstrating around the country that it can work.
9 And that people are healthier, and you begin to reduce
10 the 25-year early death rate.

11 And then the question is, how do you get the
12 personnel wrapped up? And, to me, there's two
13 answers. One is peers. SAMHSA has been leading the
14 country in helping be more formalized, how to train
15 peers, how to credential peers, how to move that thing
16 out. And I hope you'll just keep your eye on that
17 ball, because without that, we can't produce enough
18 new professionals.

19 And in Georgia, we have a thing called
20 support and wellness center that costs about one-
21 twentieth of what an active costs, and guess what?
22 Has better results than the community mental health

1 hospital. So, those things need to be supported.

2 But the other thing I haven't heard so much
3 about is how do we get the medical schools to train
4 differently? And in our little town, we have enough
5 of a crisis, we have no psychiatrists, we have a
6 paucity of other professionals a community mental
7 health center, and on one recent Thursday, 67 people
8 seen by one psychiatrist. I mean, it is horrible.
9 And the free clinic that I'm part of the Board of
10 pulled together the community leaders, the police, the
11 schools, the sheriffs, the Chamber of Commerce and we
12 said, "What do we do about this? How do we fix this?"
13 And you know what they all said? Prescribed
14 integration. They know that's the answer.

15 So, I would say we need a little more energy
16 thinking about how to hitch on to the very strong
17 integration movement that's occurring. Tomorrow, or
18 whenever the appropriate time is, I'm going to invite
19 you guys to come to Atlanta for your next meeting.
20 One of the reasons I'll do that is the strong work
21 going on by the Carter Center around integration.
22 John Bartlett's heading it up and he's got a task

1 force working and if we know more about that, we don't
2 have to invent, but we can be part of it in a very
3 concrete way. So, I really think we've got to think
4 about how to get the personnel. Part of that is
5 peers, part of it is a different training process that
6 includes doctors who are up to here and don't know
7 what to do. Then the organization, and to my mind,
8 that calls for integration.

9 Chairperson Hyde: I'm a little curious, you
10 said you didn't hear us talking about either how to
11 get the medical schools to change or hear enough about
12 integration. I thought we had talked quite a bit
13 about integration. Are you saying more about what you
14 said you weren't hearing?

15 Ms. Wainscott: I did hear about
16 integration, but what I'm proposing is we hitch onto -
17 - and maybe we already are, and I just don't know it -
18 - an existing, very strong, movement in the country,
19 you know, leaders like Cherokee and Kreider Health
20 Center and all of those kinds. And there are
21 academics that are really focused on that now, and the
22 Carter Center, and probably other people are. But, I

1 think the thing that I have not heard as much about as
2 I would like to, and maybe I'm just not hearing it, is
3 how to change the curriculum for preventive
4 practitioners.

5 Chairperson Hyde: Two things about that,
6 and again, I'm saying this to have you keep telling us
7 what are we not saying that we need to be saying or
8 working on. I, actually, it just so happened this
9 past week, got a chance to meet with Mrs. Carter,
10 whose just written a new book, and it's actually a
11 great book if you haven't read it yet. It's very
12 readable and it's a really nice, "Here's where we are
13 with the mental health system, and here's what we need
14 to do," but at any rate, she and the Secretary and I
15 met and she talked about the integration effort.

16 And as I think I said earlier, we're about
17 to release a request for applications for a technical
18 assistance center on integration, we're doing that
19 with HRSA, so we're doing that collaboratively with
20 them so that will be on the street soon. And we're
21 hopeful that some of the folks that are out there
22 already doing some of this stuff are -- will apply and

1 we'll pick the best one and go there. So, hopefully,
2 we're not trying to recreate the wheel, we're trying
3 to get folks who are already working on that to come
4 help us and be our sort of point on that.

5 We're also working with AHRQ, another sister
6 agency who's sort of trying to look at the quality
7 side of that, of the integration issue. So, we'll be
8 working with them, again, the Agency for Health,
9 Research and Quality. Do I have the acronym? I
10 always think of them as AHRQ.

11 But, these are all, I mean, the cool thing
12 is the agencies within HHS are really trying to work
13 together. The good news is, everybody wants to do
14 behavioral health so it's sometimes a challenge, but
15 how to figure out how best to do that.

16 And then the stuff that Westley talked about
17 that, I think, Arturo responded to, that is not in the
18 rural areas, yet, but I think that testing of, can we
19 get people, academic settings, we're training primary
20 care docs, can we get them to shift their training a
21 little bit? And I think we are dipping our toe in
22 that water. But anything else that you can suggest to

1 us, and again, that's a role, to tell us what you
2 think we could more of or do differently.

3 Ms. Wainscott: Maybe I've misunderstood
4 SBIRT. I thought that was substance abuse.

5 Chairperson Hyde: Well, we just have been
6 talking about, there was an SBIRT focused on alcohol,
7 there's an SBIRT focused on drugs, there's an SBIRT
8 focused on depression, and there's actually an SBIRT
9 focused on HIV. So, there are several different ones.
10 We thought about trying to see whether or not we could
11 test a screening brief intervention for trauma, I
12 mean, that would definitely be a test kind of thing.
13 So, there's lots of different ones with, somehow, more
14 evidence behind than some others.

15 Actually, one of the things HRSA raised,
16 which I thought was an excellent point, which is, we
17 talk about SBIRT as if it's one thing, and it really
18 isn't just one thing. It is a technique that can be
19 used for a lot of different purposes. And they
20 suggested -- and I haven't had a chance to meet with
21 Westley about this -- but they suggested maybe SAMHSA
22 take some role in trying to write that down.

1 So, we could be clear about the different
2 types of ways that SBIRT could be used. I don't know,
3 actually, what we already have in that regard, pulling
4 it together into SBIRT 101 might be useful.

5 Ms. Wainscott: You're way further along
6 than I had the impression you were, that's wonderful.
7 Until we do that, until we really get the primary care
8 docs comfortable with how to do it, they can't do what
9 they are doing. They're not treating it, and
10 oftentimes they don't even have a colleague they can
11 refer to and they just do the best they can. So,
12 you're way further along on that than I thought you
13 were.

14 Chairperson Hyde: The other side of that,
15 which again, your reaction is on the sides, but
16 Westley did talk about it, but we haven't dwelled on
17 it in the questions and answers, which is the comment
18 period, which is training the psychiatric professions,
19 the behavioral health professions, in a more recovery-
20 oriented approach. So, quite frankly, we can't really
21 afford to have limited health practitioners spending
22 years with the same individual, with no progress. I

1 mean, we just can't, we don't have that kind of
2 resource.

3 So, trying to get folks to understand the
4 recovery rates, there's more and more work going on in
5 putting recovery in core competencies, but that's
6 different than recovery in the curriculum for social
7 work. I mean, I don't know about those of you who are
8 psychiatrists, did you get anything about recovery
9 when you were going through school?

10 Dr. LeMelle: One of the new initiatives at
11 Columbia is exactly that -- to have a cross off four
12 years of residency, specific training in what we call
13 public psychiatry but it's basically around the issue
14 of recovery and assistance and approach to individual
15 care. And we're hoping to extend that to medical
16 students broadly, as well.

17 Chairperson Hyde: Well, we're really
18 searching for, like, the best curriculum for recovery,
19 for teaching recovery to people who are going to
20 become practitioners. So, I would love to see what
21 the curriculum looks like.

22 Dr. Rosen: Our focus on recovery -- the

1 only thing I want to say is we didn't study this with
2 a standardized patient, same area, if the chief
3 complaint was substance abuse, the provider spent an
4 average 14 minutes with them. If the chief complaint
5 was depression, the same area, and history, they got
6 44 minutes.

7 Chairperson Hyde: Was there any different
8 outcome?

9 Dr. Rosen: Yes, significantly.

10 Chairperson Hyde: More time meant better?

11 Dr. Rosen: More time meant better, more
12 accurate assessment, better disposition.

13 Chairperson Hyde: Yes, Kate?

14 Ms. Aurelius: I also think the primary care
15 should be delivered by the psychiatrist, that's who
16 they have more frequent contact with. People with
17 end-stage renal disease, to the degree that
18 psychiatrists are comfortable and supporting that, I
19 think it goes the other way, too.

20 Chairperson Hyde: Again, those of you who
21 are psychiatrists -- would psychiatrists be willing to
22 meet primary care?

1 Dr. LeMelle: It's something we've talked a
2 lot about in our community mental health program for
3 just that reason. Because we have the most contact
4 with them, and I think probably, by default, we do a
5 lot of general medical care. I think that again,
6 maybe it's a generational thing, the younger folk who
7 are coming through a lot of these psychiatry training
8 programs now tend to be more willing to take on that
9 role. I think that some of the older folk who have
10 been out in the community for a long time don't see
11 themselves as primary care physicians, they see
12 themselves purely as psychiatrists. But I do think
13 that it is something that can be incorporated into the
14 training for those who are inclined to do that, and
15 sort of wear their medical hat, not just their
16 psychiatric hat. That there is a large number -- or
17 larger number -- who are willing to do that.

18 Ms. Aurelius: If psychiatrists are going to
19 take that on we have to provide appropriate support
20 for that, we have to have a team in there with nurse
21 practitioners and availability and a consult with
22 somebody else that has to be appropriately supported.

1 Dr. Rosen: So, we have a primary care
2 psychiatry track to track the residency training
3 program that that residents rotate through the
4 psychiatry track that's staffed by both internists and
5 psychiatrists so that the psychiatrist sees the
6 patient, tends to the non-psychiatric medical issues,
7 tends to the psychiatric medical issues and depending
8 upon which one needs supervision, both supervisors are
9 there.

10 We also have a consultation, it's called a
11 general medical psychiatry rotation, and so we are
12 steeped as we can make it in the primary care
13 psychiatry model.

14 Chairperson Hyde: Terrific. Well, we may
15 come back to both of you to get some more. We won't
16 ask you whether you're in the younger or the older
17 generation.

18 [Laughter.]

19 Chairperson Hyde: Westley, anything else
20 you want to add, wrap up?

21 Dr. Clark: Thank you very much.

22 Chairperson Hyde: Great, thanks. This was

1 a great conversation. Great day, lots of terrific
2 conversation.

3 We are going to move, now, into public
4 comment. We're going to have Toian tell the people on
5 the Web how they can call in. There are at least a
6 couple of people in the audience, here, who wanted to
7 comment. If you haven't, let us know that you want to
8 comment. We need you to just come up here and let us
9 know that.

10 And don't forget that at 5:30, so after we
11 take these comments, at 5:30 we should have Gil
12 Kerlikowske here. And this is a little bit like when
13 you're in an airport, and the plane is a little late,
14 Gil's not late yet, but we're not sure -- he might
15 come in a minute or two early, so don't go too far
16 away from the gate. So, stay in the general vicinity
17 because as soon as he gets here, we will get him on
18 for all of you to hear.

19 So, Toian, you want to tell us what the
20 process is? Then we'll start with the people in the
21 room, and then go to the people on the Web. And
22 Council, this public comment is as much for you as it

1 is for us. So, I hope you will be able to hear and
2 participate in that, as well.

3 Ms. Vaughn: I would like to make a comment
4 to those individuals that are on the line. Okay,
5 those individuals that are on the line need to call
6 into the following number, 1-800-857-9877. Again,
7 it's 1-800-857-9877. Then you are to use the
8 password, SAMHSA.

9 Chairperson Hyde: Do you want to say that
10 one more time?

11 Ms. Vaughn: The number again is 1-800-857-
12 9877. The password is SAMHSA.

13 Chairperson Hyde: Okay. So, while that's
14 going on, we have at least one person in the audience
15 to call on, here.

16 Nancy Carstedt, Abraham Law Self Help
17 Systems?

18 Ms. Carstedt: My name is Nancy Carstedt, I
19 am the CEO of Abraham Well Self Help System, which was
20 formerly known as Recovery International. It's a
21 self-help, community-based group effort, sort of,
22 similar to what AA is to substance abuse community

1 recovery has been to the mental health community.
2 It's a 72-year-old organization, based on a CBT
3 approach. And 27 years ago, I actually underwent
4 treatment for alcoholism, and 25 years ago, I spent 15
5 months in a psychiatric hospital being treated for
6 depression. So, I love your new branding, "Treatment
7 works, people do recover." And I think it is that
8 story and the hope that is embodied in the story of so
9 many of us consumers that really makes the consumer
10 element of the work we all do so powerful.

11 So, I just wanted to say thank you to SAMHSA
12 and to all of you for your leadership in really moving
13 the consumer movement, the consumer-run organization,
14 self-help practices forward.

15 And I hope that as you go forward in meeting
16 your initiatives and developing future programs and
17 plans that the consumer will continue to be a very
18 important element in your planning and development of
19 practices.

20 I had, sort of, an observation and a
21 comment. I first learned about your strategic
22 initiatives a couple of months ago at the National

1 Council on Behavioral Healthcare in Florida. And my
2 first reaction was, "Wow, they're really ambitious."
3 And this has been a great day today, and I really
4 enjoyed listening to the sort of meat you put on the
5 bones of what I heard down in Florida.

6 But, I guess if I have a concern, it would
7 be that you don't try to take on too much at one time.
8 I sort of had my schooling in non-profit organizations
9 from a fellow named Peter Drucker. And Peter Drucker
10 was fond of saying, "If you have more than three
11 goals, you don't have anything." So, for whatever
12 that's worth, thank you for all you're doing, and
13 continue your good work, and we look forward to
14 working with you.

15 Chairperson Hyde: Thank you very much. And
16 if you, or anybody, has any way to tell us what to
17 take off of this list, you can let us know. We
18 thought keeping it down to ten was pretty good. There
19 was a lot of pressure to do more, but I think you're
20 right -- if you have thoughts about any of that, you
21 can let us know.

22 Faye Gary, our very own Faye Gary from Case

1 Western Reserve.

2 Ms. Gary: Thank you, Administrator Hyde.

3 And I would like to thank my colleagues who are on the
4 Council, I really appreciate your insights and your
5 commitment to making life better for all people in our
6 Nation.

7 I had, since I couldn't talk, I made a list
8 of things that I would like to share, and this really
9 comes from Dr. Kirk. And that is with regard to
10 psychotherapy.

11 I would like to point out that because of
12 the reimbursement structure, psychiatrists, typically
13 in the community don't do psychotherapy, they do bed
14 checks. And that's because of the reimbursement
15 structure. And other healthcare providers such as
16 nurses, social workers, and psychologists typically do
17 therapy.

18 Now, that's happened in the last 20 years,
19 so I would ask that when we consider integration, we
20 also look at integration from the perspective of the
21 kind of care that patients get and who does what, and
22 what is the continuity of that kind of care, and what

1 is done in the best interest of the patient. I think
2 that's a basic philosophical and policy issue that we
3 might need to take a look at. I know how it works in
4 both systems, and I suggest that when a patient can go
5 and have psychotherapy and med checks with the same
6 provider -- and that could be a nurse practitioner as
7 well as a psychiatrist and patient -- that they have a
8 sense of belonging someplace, and a sense of
9 continuity of care. So, I would just like to bring
10 that observation forward.

11 The other issue that I would like to make
12 relates to the HIT program, the IT HIT programs. I
13 noticed that the agencies or institutions that have
14 received grants -- and I don't know the process for
15 the grant funding -- but they were agencies that
16 typically get monies from the Federal government, such
17 as Duke University -- excellent place -- Columbia --
18 very excellent institution. But when I was looking at
19 that list, the question came to me about
20 spreadability. It's a word that is new to me, but I
21 like it. And I would suggest that as we look at
22 funding programs in IT and in other areas, that we

1 consider populations that have the greatest burden for
2 the disease, such as individuals on Indian
3 reservations, people in urban communities, and fund
4 technical schools in urban communities. Fund and put
5 some of these programs in -- on reservations and also
6 in Hispanic-serving institutions and in historically
7 black institutions.

8 Now, what that gets for you is a whole
9 different set of stakeholders who can help you spread
10 information to populations of people that we may not
11 yet have reached. I just would like for you to think
12 about that, and I can certainly help you dialogue
13 about how that can happen.

14 The other piece is that, I was thinking
15 about, once we make contact with people in tribal
16 communities and vocational technical schools,
17 community colleges, historically black colleges and
18 universities, we can set up a structure where they can
19 become our partners, and then we could ask them to
20 stay sustained in their relationships with
21 headquarters, meaning SAMHSA, and go out and have town
22 hall meetings with individuals in their communities at

1 another level that would give us another layer of
2 individuals who would get basic information about
3 healthcare -- especially mental health and substance
4 abuse care. I think this is essential, because many
5 people who have never been insured who have problems
6 and who've managed all of their lives without any
7 intervention don't know how to use the mental health
8 system. They not only don't know where it is, but
9 they don't know how to use it.

10 And I know that the National Cancer
11 Institute has funded many programs across the Nation
12 where they have what they call navigators. So, if you
13 have cancer, God forbid, but if you go to a hospital
14 that is a national cancer center, you get a navigator,
15 you don't have to look for x-ray, you don't have to
16 look for where you get your blood drawn, you have
17 someone there to support you through that entire
18 process.

19 And I don't know what's any more devastating
20 than hearing voices or seeing things that other people
21 don't see. Somehow, in my mind, that supersedes the
22 kind of pain and anguish that one has with cancer.

1 But, I think it is the way that we frame the issue,
2 and the whole issue of stigma can be addressed as we
3 get different stakeholders during the process that I
4 just mentioned. Because stigma will have to be
5 addressed, and Dr. Kirk and I were talking about
6 stigma that exists among healthcare professionals. I
7 think somehow we need to understand that that does
8 exist, and we need nurses, physicians, dentists,
9 others have stigma about mental illness. And maybe
10 that is a part of our responsibility to address that
11 kind of concern.

12 One of the last comment that I would like to
13 make is that when my family and I talk about mental
14 health care -- and I've devoted my whole career to the
15 care of mentally ill children and families -- they say
16 to me, "Well, how in the world can you justify
17 homeless people living all over the world, in the
18 streets, and you call yourself a committed mental
19 health provider?" That's what my family and friends
20 say to me. And I need to ask you, my beloved friends
21 and colleagues, how can any of us call ourselves
22 committed to mental health when, in every city in the

1 Nation there are people sleeping on the streets and
2 displaying their private hell in public, with
3 hallucinations, delusions, illusions, and we pass
4 right by? I would hope that we would think about a
5 special, signature project, where we would look at
6 eliminating and reducing homelessness.

7 Now, the other thing that that will do, I
8 think, would be to bring some credibility to us, as
9 mental health professionals. If we don't care about
10 the mentally ill, then who should?

11 Thank you very much.

12 Chairperson Hyde: Thank you very much. And
13 I hope you're here tomorrow to listen to our
14 initiatives. I think you will like that effort.

15 Is there anybody else in the audience? Do
16 we have any other names?

17 [No response.]

18 Chairperson Hyde: Okay, so we'll go to the
19 people online. Do we have people online who are
20 interested in making comments?

21 [No response.]

22 Chairperson Hyde: No? All right.

1 My understanding is we still have about 80
2 people or so online, or with us electronically. Just
3 so you know, there's still an audience out there.
4 We're going to take a break, but you all should stay
5 on electronically. As soon as Gil gets here, we will
6 reconvene and have him relate to us about the National
7 Drug Control Policy, or strategy. He is coming out
8 here from D.C. to do that just for us. And I think
9 there's going to be some Drug-Free Community folks
10 joining us. So, there will be some additional people
11 in the audience joining us for that, as well.

12 So, we will be back here, unless anybody
13 else has any other final thing to say. Well, we have
14 a little bit of time for break, so again, those of you
15 online, stay with us. And we will be back, we'll let
16 you know as soon as Gil arrives, hopefully it will be
17 no later than 5:30, maybe a little sooner.

18 Thanks.

19 [Recess.]

20 Chairperson Hyde: So, do we have Guillermo
21 Valenzuela? Did I say that right? Close enough, huh?

22 Welcome. Yes, and just for those online,

1 here, we are back in session here after a short
2 recess, and we're hearing from more public input, and
3 then we'll catch up on where we are with Mr.
4 Kerlikowske.

5 So, go ahead.

6 Mr. Valenzuela: Good afternoon, thank you
7 for the opportunity to provide public comment. My
8 name is Guillermo Valenzuela, Director of External
9 Resources for Aliviane Incorporated, a non-profit,
10 community-based organization headquartered in El Paso,
11 Texas.

12 Aliviane began providing services in the
13 1960s, and is now one of the oldest, and most
14 experienced behavioral health, addiction, addiction
15 treatment and prevention systems along the
16 Texas/Mexico border. Some of our centers are yards
17 away from Ciudad Juarez, the epicenter of the
18 U.S./Mexico drug war and the most violent city in the
19 world.

20 As of May 10th, 2010, there has been more
21 than 800 murders in Ciudad Juarez, raising the total
22 homicide count to more than 5,000 in just 2 years.

1 More than 129 of those have been American citizens.
2 The violence on the U.S./Mexico border cannot be
3 characterized as one-dimensional, or merely a drug
4 cartel turf war. In fact, each State and region along
5 the border is confronted with its unique problems on
6 account of the violence.

7 However, what remains constant is the level
8 of violence, trauma and substance abuse that our
9 border communities experience that is unlike any other
10 part of the country. Substance abuse rates in border
11 States are epidemic. It is imperative that substance
12 abuse be treated like a communicable disease that
13 knows no borders.

14 Our communities face a number of challenges,
15 including the aggressive recruitment of our children
16 for drug trafficking and hired killings. California,
17 Arizona, New Mexico, and Texas desperately need border
18 impact aid in the form of \$65 million for prevention,
19 treatment, and support services. It is critical that
20 SAMHSA continue to take the lead on the crisis
21 impacting the U.S. and Mexico border. Amidst the
22 escalating violence, you have shown great border

1 leadership, and now more than ever, our communities
2 are in urgent need of your help.

3 Thank you.

4 Chairperson Hyde: Thank you very much.

5 You all have a copy of the presentation that
6 Guillermo just made, and we will make sure that this
7 gets to Director Kerlikowske, as well, because I'm
8 sure he will be interested in hearing this. We did
9 meet with the First Lady of Mexico in February to talk
10 about some of these issues in Mexico and in the United
11 States, so this is helpful information, thank you.

12 Is there anybody else out there who wants to
13 do public testimony at this point, or anybody else on
14 the line?

15 [No response.]

16 Chairperson Hyde: So, here's what we know
17 about Director Kerlikowske: he was in the car as of
18 about five till five. We are trying to ascertain
19 whether or not he can make it here by 5:30, and if
20 not, we may try to go ahead and have him on the phone,
21 and do the presentation that way.

22 So, if you want to, again, just hang close,

1 just a little bit, here, Mark will be back down in
2 just a second to let us know where he is at, and what
3 we're going to do about that. So, more cookies, more
4 coffee, more sugar.

5 We are going to go get copies of the
6 Executive Summary of the National Drug Control
7 Strategy, so we'll bring that down so you all can look
8 at it. It's short, it's an Executive Summary, but we
9 can look at that while we're waiting on Director
10 Kerlikowske.

11 [Recess.]

12 Chairperson Hyde: The question is, does the
13 Executive Summary of the Drug Control Strategy address
14 some of the border issues? I think it does. You're
15 welcome to ask Gil that when he appears. That's why I
16 thought you might appreciate having it.

17 I'm also open, at this time, if you want, if
18 there's any other comments that we either cut off
19 because of time or that people thought of since then
20 or anything else you wanted to talk about. We have 10
21 minutes or so while we're waiting to figure out what
22 he's doing. So, anything anybody just can't stand not

1 saying?

2 Ed?

3 Dr. Wang: Since I have not heard about this
4 and I want to, maybe, put a little emphasis on
5 healthcare, especially when we talk about "prevention
6 works," I heard Dr. Clark talk about, in terms of the
7 workforce getting burned out, I understand the salary
8 is very low, I don't think that this is going to be
9 drastically going to change in the next few years in
10 the mental health field. And I wonder whether this is
11 a potential for SAMHSA to take the leadership of
12 emphasizing self-care, especially when we talk about
13 integrating primary care and also behavioral health?
14 Some of our direct service staff are out there in the
15 front line, very, very stressful work for themselves.
16 And, I mean, talk about potential of drug addiction,
17 potential of their own depression and other forms of
18 mental illness. I think self-care, in some sense, is
19 just as important as raising someone's salary. And
20 I'm wondering whether there's a way to tie into
21 "prevention works," but a little emphasis about taking
22 care of yourself. What does that mean? Really, take

1 the leadership for behavioral health, as well as
2 primary healthcare.

3 Chairperson Hyde: That's an interesting
4 idea, a great idea. Would you have theories about how
5 we would do that? Like, what is it we should say to
6 people about that?

7 Dr. Wang: Well, not right this minute --

8 [Laughter.]

9 Dr. Wang: I think I have some opportunity
10 sitting to listen to some of the direct care service
11 providers and listening to what they say and what the
12 needs are and so forth. I will take your offer --
13 maybe I can put thoughts together from people who are
14 doing that in the field and really feeling stressed
15 out.

16 Chairperson Hyde: That would be great, give
17 us that.

18 Flo, I think you had your hand up?

19 Ms. Stein: This issue is kind of related to
20 workforce, that is, some States have gone ahead and
21 licensed their addiction specialists at the Master's
22 Degree level, and our universities have invested a lot

1 of money in producing this new healthcare
2 professional. But, Medicare regs will not allow them
3 to -- not Medicaid, but Medicare, so it's really
4 affecting us in our services to military families,
5 because it's actually the Medicare regs that prevail
6 in Tricare. And so, this is something we want
7 somebody to look into, or go with us. I will go, but
8 I need help.

9 Ms. Aurelius: I think the Medicare benefit
10 for behavioral health services is extremely limited,
11 right, isn't it? Thirty inpatient days and thirty
12 outpatient site visits? Isn't that the entire
13 benefit? Last I knew.

14 Ms. Stein: It's true, and -- but it also is
15 very limiting on who is eligible to provide it. And
16 so Tricare picks that up, and that's the problem.

17 Chairperson Hyde: I'll actually ask you to
18 make a note, and bring it up tomorrow when we talk
19 about military families. Because Kathryn and I have
20 actually taken on -- she's doing most of the work, but
21 we went to an initial meeting that sort of kicked that
22 off -- on getting Tricare to work differently with

1 civilian providers. Civilian, meaning, you know, not
2 in the veterans' system or not, whatever, in the
3 community system. Because they do have a little bit
4 of -- a little bit -- they have a narrow view of who
5 they will credential and who they will use to treat.
6 And there's some interest on the Defense Department,
7 Defense and Veterans Administration and Guards' part
8 to sort of open that up a little bit. Because they're
9 having good response from family specialists that they
10 put in place, really, not for behavioral health
11 issues, but for things like divorce and, you know,
12 separations, and things like -- separation because of
13 deployments and stuff like that. And it's worked so
14 well that they're sort of starting to get that maybe a
15 self-help or other kinds of professionals could be of
16 use.

17 But, Kathryn will have more information
18 about that tomorrow, so please ask that again.

19 Does anybody else have anything they want to
20 put on the table right now? Well, let me see what we
21 have found out, here.

22 Okay, so what we have learned is Gil is on

1 his way and he's either 10, 15, 20 minutes away. So,
2 it may be a little later than 5:30, but he's on his
3 way to talk to us, so we're going to wait until he
4 gets here.

5 Okay, so this -- it should have gotten
6 passed out, everybody should have this in front of
7 them? This is the very high level summary and I'm
8 sure that Gil will talk more about it, and we have
9 lots more information than this, and he may have stuff
10 with him, as well, but at least it will give you a
11 sense of what the content is that he may be ready to
12 talk about.

13 So, those of you who are on the line, or on
14 the phone, hang on with us, we do plan to have this,
15 it just will be a few more minutes.

16 [Recess.]

17 Chairperson Hyde: Okay.

18 So, you're getting another version of this,
19 it's -- apparently this is the very same information,
20 just in a different format so you'll have two ways of
21 looking at it.

22 And, do we get this posted on the Web at

1 some point, so they can -- so people who are joining
2 us by Web can see this stuff? All right.

3 Before Gil gets here, let me just do a
4 couple of logistics things, because as soon as he's
5 done we're not going to want to do this.

6 So, you all are on your own for dinner
7 tonight, I hope you have ways to either enjoy your
8 alone time or enjoy your networking time, whichever
9 you decide to do.

10 And then, tomorrow morning, we're going to
11 start at 8:30. We really are going to start at 8:30.
12 We got through 6 of the 10 today, but we're going to
13 try to end a little earlier tomorrow, because some of
14 you have planes and other things, so we're going to
15 get through four tomorrow and then we have a
16 presentation from Tom and Faye, I think it is, or from
17 Tom, I'm not sure which -- but, anyway -- a paper that
18 you were provided that they want to present to us, and
19 some more time for public comment, so we'll be
20 starting at 8:30. There will be coffee here, but not
21 really breakfast, so -- it's available at the hotel,
22 so there you go, you're taken care of at the hotel.

1 So, I think that's it, in terms of logistics
2 for tomorrow, 8:30, ready to go. The taskmaster.

3 We've done a good job at staying on time
4 today, so we have some time to chat.

5 So, did everybody hear that? If you don't
6 want to take your materials with you, you want to
7 leave them, then Toian and her folks will make sure
8 that it gets shipped to you, if you don't want to lug
9 it through the airport, tomorrow.

10 Ms. Vaughn: Make sure you put your badge on
11 top of your materials, so we won't get them confused.
12 So, don't take your badge with you.

13 Chairperson Hyde: And then should people
14 leave their stuff here tonight or is this room getting
15 cleaned up? Or, what should they do tonight?

16 Ms. Vaughn: You know what? They can leave
17 it here if they wish, we can lock the room, so if
18 that's what you'd like to do.

19 Chairperson Hyde: All right, so if you want
20 to leave your stuff here, you can. We just need to
21 make sure that the cleaning people know that and don't
22 clean up everything.

1 Any other questions about logistics, or
2 tomorrow, or any of that kind of stuff? Does
3 everybody know how they're getting to airports and
4 places? Cabs are coming here.

5 Anybody got any jokes?

6 [Laughter.]

7 Chairperson Hyde: So I also just want to
8 say welcome to the people who are here from the drug
9 free communities program. Hello out there.

10 [Applause.]

11 Chairperson Hyde: Great to have you. And,
12 I also -- I don't mean to put her on the spot here --
13 but just so you know, but SAMHSA's OMB analyst, or I'm
14 not sure what we call you Laurie, but has been here
15 all day long listening to this wonderful conversation,
16 so thank you for being here, being interested. You've
17 spent a lot of time out here in the last few days and
18 we like that. So, terrific.

19 Is there anybody else out there we should
20 acknowledge?

21 There's also some SAMHSA staff in the room.
22 Why don't those of you who are SAMHSA staff just kind

1 of wave your hand a little bit so the council can see
2 some of you. Yeah.

3 [Applause.]

4 Chairperson Hyde: Terrific. Then the
5 people behind the cameras, Toian, shall we give them a
6 little acknowledgement here?

7 [Applause.]

8 Chairperson Hyde: You want to see the video
9 first?

10 And then actually, Toian, why don't you take
11 a minute to introduce the people who are helping you,
12 because this has been a terrific day and they do a lot
13 of quiet support, so why don't you do that.

14 Ms. Vaughn: Okay, this is our first time
15 using this particular company. Mark Mendez and I'm
16 not -- Mark, you will have to introduce the other two
17 gentlemen, because I don't know their names.

18 Mr. Mendez: JD Mack and Dave Smalley.

19 Ms. Vaughn: And Dave is behind the podium.
20 And we want to acknowledge the work that Carol
21 Watkins, who is the designated federal official for
22 the Center for Mental Health Services Advisory

1 Council, who has been supporting us today. Carol has
2 just done a yeoman's job in helping us with things,
3 keeping things flowing properly.

4 And Tia Haines, who is the designated
5 federal official for the Center for Substance Abuse
6 Prevention, was also with us this morning, who also
7 provided support.

8 Chairperson Hyde: What about these gals
9 over here?

10 Ms. Vaughn: Okay, Michael is the Office of
11 Program Support SAMHSA staffer. Katie Kostiuik from
12 Cabezon, and we all work as a team.

13 Chairperson Hyde: We're just looking for
14 something to stretch out here.

15 [Laughter.]

16 Ms. Vaughn: Two additional Cabezon
17 staffers, Josh who is with us in Portland and Rachel.
18 I don't know their last names, I'm so sorry, but Josh
19 and Rachel who have been supporting us. And we have a
20 transcriber, the young lady who will be writing our
21 minutes and who will be giving us highlights of the
22 two day discussions with a very quick turnaround time,

1 is Irene Goldstein. She's been with us for several
2 years, and we've been very pleased with the support
3 she has provided to us. And the transcriber --

4 Mr. Heer: Raymond Heer.

5 Ms. Vaughn: Raymond Heer, and you're with
6 which company?

7 Mr. Heer: Alderson Reporting Company.

8 Ms. Vaughn: Alderson.

9 Mr. Heer: Alderson.

10 Ms. Vaughn: Okay, we've used you before,
11 once before I think. Thank you.

12 Mr. Heer: We must have done okay then.

13 Ms. Vaughn: Yes, you have been.

14 [Laughter.]

15 Chairperson Hyde: Well, thanks to everybody
16 who's helped make this happen.

17 Ms. Vaughn: Marion Selby. All of the
18 conference technical work that goes into this meeting
19 is with -- Marion Selby has been providing that, he
20 supports all the conference rooms on this floor and
21 throughout the building. I don't see him around, but
22 I'm sure he's watching us on video. So we want to

1 thank him as well.

2 Chairperson Hyde: So we get lots of good
3 support in putting this on. Has everybody got the
4 paper for tomorrow, it is called, a think tank. Is
5 that what it's called? Say you all have that, you've
6 already read it, or do you have to do homework
7 tonight.

8 Well, so our latest is that he's close,
9 minutes, minutes at this point. I mean, I just can't
10 thank you enough for staying, because he, you know,
11 for him to take this time to drive all the way out
12 here is really a big deal and they have been
13 incredible partners with us, so I do appreciate all of
14 you hanging until he gets here. And I hope there's
15 still folks on the web listening as well.

16 Chairperson Hyde: Okay, we're going to get
17 started here again. It is my great pleasure to
18 introduce to you, Director Kerlikowske from the White
19 House Office of National Drug Control. I'm going to
20 ask -- just to give him a breather to let him get
21 settled -- then I'm going to ask if you guys will go
22 around and just do two minutes about who you are.

1 This is our National Advisory Committee, so you will
2 get a flavor of where they come from in the country.
3 And I think we have everybody here but one or two
4 people.

5 So why don't you start over here. Kate?

6 [Cross talk.]

7 Mr. Gonzales: Good afternoon, I'm Arturo
8 Gonzales, I'm with Sangre De Cristo Health Center in
9 Santa Fe, New Mexico.

10 Mr. Alexander: Marvin Alexander, I'm
11 Coordinator in Community Mental Health Center in
12 Jonesboro, Arkansas, and I'm also a member of the
13 National Youth Organization known as Youth Move
14 National.

15 Dr. LeMelle: Stephanie LeMelle from New
16 York Columbia University, New York State Psychiatric
17 Institute.

18 Ms. Wainscott: Cynthia Wainscott, from
19 Atlanta, Georgia. I've been affiliated for years with
20 Mental Health America and have been on the National
21 Council on Disability, and please say hello to Tom
22 McClellan who I served on the Institute of Medicine

1 Committee with recently.

2 Mr. Braunstein: George Braunstein, the
3 Executive Director of the Fairfax Falls Church
4 Community Services Board, so I'm a neighbor, and I'm
5 also the public policy chair for the State Community
6 Service Board System for Virginia.

7 Ms. Cushing: Judy Cushing, Oregon,
8 partnership, and I won't bore you, you know me.

9 Dr. Rosen: I'm Don Rosen, I won't bore you
10 either. I'm also from Oregon Health and Sciences
11 University.

12 Ms. Stein: Flo Stein from North Carolina
13 from the Division of Mental Health, Developmental
14 Disabilities and Substance Abuse, and president of
15 NASADAC, and good to see you.

16 Dr. Wang: Ed Wang, Massachusetts,
17 Department of Mental Health.

18 Chairperson Hyde: And out in the audience
19 are a number of SAMHSA staff and drug free communities
20 folks and others, and there are a few people listening
21 by web. So it's yours.

22 PRESENTATION OF R. GIL KERLIKOWSKE, OFFICE

1 OF NATIONAL DRUG CONTROL POLICY

2 Mr. Kerlikowske: Thanks very much, Pam.
3 It's felt like we've been together all day since CNN
4 at six o'clock this morning. I still have my makeup
5 on. It seems to be holding up very well.

6 [Laughter.]

7 Mr. Kerlikowske: That stuff is great and it
8 makes you so much younger.

9 [Laughter.]

10 Mr. Kerlikowske: I very much appreciate you
11 working so late, and I know they pay you so well to be
12 on the Advisory Board.

13 [Laughter.]

14 Mr. Kerlikowske: So I'm sure you're on time
15 and a half now because it's after five o'clock, but we
16 were very, very pleased today to be able to release
17 President Obama's first national drug control
18 strategy. I had an opportunity, along with Dr.
19 McClellan, yesterday to go over and spend about 20
20 minutes briefing the President on it. Last year when
21 I first took the job and we were talking about the
22 strategy, his direction was very clear, and he said,

1 "I want as many voices at this strategy as possible."
2 Tom and I just thought we'd sit around on the weekend
3 and write that thing up and crank it out, and the
4 President had some very different ideas. He really
5 wanted to hear the voices of people across the
6 country.

7 And so we traveled all over, we held a
8 number of round table discussions, people in recovery,
9 people in going through rehab, drug court
10 professionals, law enforcement groups from roll calls
11 in Manhattan and Fresno, California. We talked to
12 people that were on prevention programs, people that
13 administer treatment. We spent a lot of time with
14 young people, and really got quite a bit of advice and
15 information.

16 So even though we had the pen for the
17 strategy, the strategy is really written by the people
18 across the country, and we believe it is
19 comprehensive, we believe it's a very smart approach,
20 we believe it's a balanced approach. We truly believe
21 that the right team got selected and the right voices
22 have been heard. We just picked a lousy economic time

1 to put all this together, but it strongly suggests
2 that prevention and treatment should receive as much
3 focus and as much attention as the criminal justice
4 lens has had on the drug problem for a good number of
5 years.

6 Let me mention a couple of things in
7 particular about the strategy, and then I will be
8 happy to answer any questions. But we believe it
9 dovetails very, very nicely with these strategic
10 initiatives of SAMHSA, the working relationship over
11 many years and the working relationship now with
12 SAMHSA, I think is particularly strong. People that
13 have come from local levels of government, people that
14 have come from and worked at the State level of
15 government, and then the people within SAMHSA and the
16 people on the staff, the career staff at ONDCP, which
17 is an incredibly talented and marvelous staff, and I'm
18 so privileged to work with them because they've been
19 on the front lines of trying to work through these
20 strategies and try to develop a comprehensive way of
21 looking at this. Sometimes it just always doesn't get
22 the attention that it deserves, but this strategy has

1 gotten a lot more attention than even some people had
2 expected.

3 It couldn't have picked -- let's see,
4 Supreme Court nominee, Afghanistan jobs, the economy,
5 there was something going on with healthcare I
6 understand recently, et cetera. But this strategy is
7 actually one that has received a lot of attention, and
8 whether it was the 700 people that had signed on for
9 the phone call today, the number of people that
10 attended at the foreign press office at the press
11 club. It's just gotten a lot of attention because I
12 think people -- and I told the President this -- I
13 really think this country is ready for and wants a
14 different conversation about the way we have dealt
15 with the drug issues, which primarily has been about
16 criminal justice.

17 The President's 2011 budget request includes
18 a 13 percent bump in prevention programs. It's a
19 little less than 4 percent in treatment, but we also
20 think that one of the most important parts of this
21 strategy is the collaboration and partnerships. A
22 woman in New York, I think described this very well to

1 me. She runs a prevention program and she had lost a
2 son to a fatal drug overdose, she knows the system
3 very well. And she said, "We do prevention, treatment
4 is over here, law enforcement, criminal justice is
5 over here." She said, "We're a family." She said,
6 "The problem is, we're a bit of a dysfunctional
7 family." And she said, "In fact, it's the only family
8 I know that when the going gets tough, we circle the
9 wagons and shoot in." And she was exactly right,
10 prevention programs say, "Look, it's much smarter to
11 prevent than to have to treat. Why don't you take
12 some money from them?" Treatment programs say, "Look,
13 all the police want to do is arrest people and seize
14 the drugs and put people in jail." You should take
15 the money from law enforcement, we really believe that
16 a comprehensive approach and one that leverages
17 resources makes a lot more sense than trying to figure
18 out what part of the dollar.

19 Over and over again I get the criticism,
20 well, the budget hasn't moved that much or the needle
21 hasn't moved that much, as if in this incredibly
22 difficult and complex problem of drugs, that we can

1 put everything into just such a simple pie chart of
2 supply and demand. Well, everyone in this recognizes
3 there isn't a drug budget, there isn't any line item
4 that suddenly says -- and this is the United States
5 drug budget, there's a bunch of really smart people
6 trying parse out where that money goes.

7 Quite frankly, it's been a subject of
8 debate. Quite frankly, it means it's very important
9 to about 12 people, most of whom are inside the
10 beltway, but it doesn't mean much of anything to
11 people out there on the front lines center delivering
12 the services and that are trying to make things work.
13 We also think that the collaboration that is talked
14 about, the fact that the criminal justice system and
15 the treatment system and the prevention system could
16 really leverage their resources in much smarter ways.
17 That the way we purchase treatment could be done in a
18 very smart way. We think that prevention prepared
19 communities, which SAMHSA is going to run, is going to
20 be a highlighted example.

21 The other part that was so wonderful about
22 not only the voices of people outside the beltway, we

1 had 34 Federal agencies that all came to the table.
2 They not only came to the table with well over 140
3 employees enthusiastically, they came to the table
4 more than willing to give up money and turf and
5 resources to make things work. Prevention prepared
6 communities, as a part of HHS, a part of justice, a
7 part of a whole host of other organizations.

8 The Justice Department said, "Look, we're
9 perfectly happy having SAMHSA run this. We're
10 perfectly happy putting our money, our resources into
11 somebody else's budget," because we have some good
12 working relationships that were established through
13 the interagency workgroup. So a host of things in the
14 budget, a number of action items that are specific and
15 are tasked out, and there are a number of measures
16 that are also in there, bringing attention to drug-to-
17 driving, which has received very little attention.

18 You know if you text and drive it is all
19 over the news. There's always some article about
20 texting and driving. Quite frankly, drug-to-driving
21 is a significant problem, it has not received the
22 attention that it should. The prescription drug abuse

1 problem, which is not coming across any border, but
2 it's coming right out of our own medicine cabinets and
3 has driven the spike and overdose deaths, has not
4 received the attention that it should, and the
5 programs that can help to reduce it. And then to deal
6 with the co-occurring disorders, how can we be smarter
7 about not having to parse out that someone belongs in
8 this silo or someone belongs in that silo, when in
9 fact all of these things are so interconnected. I
10 would say if there's one theme in particular, it's
11 breaking down silos.

12 So with that, I'm happy to turn it over to
13 Pam for a few minutes, because I think she may have
14 some comments on the strategy that she very graciously
15 made on the reporter phone call, and the questions
16 that she has answered. And then we'll be happy to
17 answer any questions about the strategy.

18 Chairperson Hyde: Thank, Gil.

19 I actually thought I was done for the day.
20 I didn't know I was going to have to do anything else.
21 It is true, I have watched this process from a
22 distance for some time, and seen the drug czar over

1 here doing that person's thing, and the SAMHSA doing
2 their thing, et cetera, and it's been really
3 gratifying to have the kind of working relationship.
4 There's a ton of stuff in this strategy, so hopefully
5 at some point you'll get a chance to really look at
6 that. And there's -- what is it, six major goals, is
7 it five, six, I'm focused on the ones that are, so I
8 apologize, I don't know the whole total number, but it
9 does range from prevention to treatment, to
10 interdiction issues and other things.

11 We have two or three major things and SAMHSA
12 has a whole bunch, but three big ones. You've heard
13 about prevention prepared communities. That one is in
14 our Fiscal Year 2011 budget, and we also have an
15 increase in our ATR or Access to Recovery Program in
16 there.

17 And then the third thing is a major data,
18 community data program, but I don't we talked -- he
19 talked a little bit about it today, but we didn't
20 spend too much time on it, but that's in the Fiscal
21 Year 2011 budget as well, to help local communities be
22 able to look at whether or not they're dealing with

1 meth or cocaine or heroin or something else, because
2 it's not all the same from New York to California to
3 Colorado to Oregon, it's all different.

4 So, all of those things are there, then
5 we're partners on a lot of other efforts, and everyone
6 of those strategies and activities is a collaborative
7 effort, so it's more than one agency on every single
8 one. We got asked a really interesting question, I
9 thought, today when we were on the press call. I left
10 you four for a few minutes and that was -- I forgot
11 what reporter it was -- but he said, "What is the one
12 message we can give our kids that would make them not
13 take drugs?" And unfortunately, the answer is, there
14 is no one message, but rather there may be some clear
15 methods. We have some good science now about the
16 methods, about parents telling kids what they need to
17 hear, schools, churches, everybody is saying the same
18 thing over and over again, a common message to kids.

19 And we talked a little bit about the ads
20 that we just released. I don't know, Mark may have
21 talked about, when he was talking about the
22 communications effort and really trying to get at both

1 parents and at kids around under aged drinking, for
2 example, or some of the other issues.

3 So anyway, a lot going on, SAMHSA is playing
4 a critical role and we really appreciate Gil's,
5 leadership, and obviously Tom McClellan has been a
6 great partner. We are sorry that he is not going to
7 stay longer. We would like him to stay longer, but he
8 made his commitment and he's done more than that. So
9 anyway, I'm going to open the floor to the council and
10 see if you all have any questions or comments you
11 would like to make.

12 As you know, Gil is -- I didn't do the
13 formal introduction -- but he is a police officer, a
14 par excellence, in addition to a community leader, and
15 has been a great spokesperson for these issues, and so
16 we appreciate it.

17 Comments?

18 Yes, Arturo.

19 Mr. Gonzales: Thank you, Mr. Drug Czar, for
20 your comments and the work that you're doing. Coming
21 from the State of New Mexico, we've become very much
22 concerned of what's happening in Juarez, and how that

1 is overflowing into El Paso and into the Las Cruces
2 area. Would you mind talking a bit about what part of
3 your strategy and prevention you're going to do in
4 that particular case?

5 Mr. Kerlikowske: I think that the important
6 things that are going on with Mexico, and I think they
7 will be really highlighted next week when President
8 Calderon and the first lady visit our -- as much in
9 demand for reduction as they are in all of the
10 technology and information sharing and law enforcement
11 initiatives that are going on, on both sides of the
12 border.

13 For example, we hosted a three-day
14 conference at the State Department just recently --
15 February, I believe -- and the first lady, Margarita
16 Savala, who has made this a signature issue about
17 prevention and treatment within Mexico, spent a day
18 and a half of the three days with us on that, the
19 Minister of Health and many other officials. We
20 looked at a number of the programs that are going on
21 in Mexico. We actually learned from them about some
22 wonderful innovative practices, because as President

1 Calderon and others have said, don't think of Mexico -
2 - and the Ambassador has also said the same thing --
3 don't think of Mexico as just a transient or a country
4 or a country that produces drugs. We are a consumer
5 country also.

6 By the way, that is what I've seen around
7 the world, the consumerism -- even in the most
8 impoverished countries in the world -- for drugs has
9 really been heightened. We also helped Mexico open up
10 the first drug court last fall in Monterrey. They're
11 making significant changes in their criminal justice
12 system and we think drug courts, because they've been
13 around and proven and effective for about 20 years
14 here in the United States, they are something they're
15 experimenting with also, and so reducing demand,
16 education, prevention, and treatment programs are, as
17 you well know, the things that we can give away as
18 much as we can on the law enforcement technology
19 interdiction side. Thank you.

20 Chairperson Hyde: Other comments?

21 Judy?

22 Ms. Cushing: Thank you, Director

1 Kerlikowske, for your leadership and particularly for
2 your interest, commitment, and following through on
3 making prevention and treatment a very critical part
4 of the drug strategy. This is really a first, and for
5 those of us in the field, if you see us smiling, we're
6 forever grateful.

7 A couple of questions. First of all, the
8 strategy emphasizes cost effectiveness and a common
9 sense approach, and those of us in the field are eager
10 for updated current numbers around the cost
11 effectiveness of prevention and treatment, and mental
12 health services, but particularly in prevention and
13 treatment. We have used some of the same numbers for
14 a long time and we get questioned by the media and by
15 other people who aren't so prone to prevention and
16 treatment and would rather legalize some drugs et
17 cetera. So we could use your office's help in those
18 numbers.

19 Secondly, we're very interested and pleased
20 about the drug-to-driving strategy within -- or I
21 would say objective within your strategy. And,
22 community members, and particularly drug free

1 communities may not know as much about this particular
2 approach and initiative as some might think, and we
3 encourage you to help provide, through SAMHSA and
4 CSAP, a way to train drug free communities on the drug
5 driving issue, and how important it is for them to
6 support and educate the public about that, so the
7 public isn't alarmed that something else is being
8 foisted upon them.

9 Mr. Kerlikowske: I don't think there's
10 anyone that will disagree that there are significant
11 problems and they've grown over the years with the
12 data sets, I mean to be citing 2006 data here in 2010
13 is the most recent data, et cetera. I mean, it's an
14 embarrassment. And somebody said, "Well how did you
15 get an entire chapter in here about the problems with
16 data?" They said, "Obviously that must have been Tom
17 or somebody else." Well frankly, actually, it was the
18 one real part I got to add. I said, "We really need
19 to have this much more relevant and timely
20 information." Everyone complains about it, whether
21 it's trying to get access to DAWN data, whether it's
22 the most timely FARS data, et cetera.

1 We would never operate a police department
2 in a major city talking about crime and say, "Well, we
3 really only have 2006. I know you might think crime
4 is going up here this year, but in 2006 it was thus
5 and so," so the data is an embarrassment, and we
6 really -- we really intend to put strong efforts on
7 getting the data sets more timely, more accurate, and
8 more meaningful so they can -- so that they can be
9 used and understood.

10 And then the drug-to-driving -- when I took
11 the office I was called and somebody said, "Did you
12 know about the 2007 study the Department of
13 Transportation did on drug-to-driving that's never
14 been released?" And I said, "Well, you know, it's
15 2009, maybe we ought to take a look at it," and DOT
16 came over and briefed us on it and said that this was
17 the first time we'd ever tested in the road side
18 survey for drugs. We tested for 40 years about drunk
19 driving or alcohol impaired driving, and we in this
20 country have made significant improvements in alcohol
21 impaired driving. And not to say that more should not
22 be done, but the drug-to-driving -- when 16 percent of

1 the people on a Friday and Saturday evening tested
2 positive for a licit or an illicit drug and we were
3 not talking about that, I thought that was wrong. And
4 they said, "Well, you know, one of the problems," and
5 the scientists were quite right, "one of the problems
6 is how do you really tell levels of impairment and on
7 and on."

8 Honestly, there will be 15 more drug czars
9 before science will ever tell us how many joints over
10 how many times does it take before somebody is
11 actually an impaired driver, or how many hours after
12 Ambien was taken, and now they're impaired, et cetera.
13 And I said, "You know, we'll be forever figuring that
14 one out." We have a clear simple direct message in
15 this country about drunk driving or alcohol impaired
16 driving, don't drink and drive. Shouldn't we be
17 putting this information out and shouldn't we be
18 saying don't do drugs and drive a car?

19 And when I went to Secretary Ray LaHood who
20 is a very bottom line common sense kind of person
21 also, he immediately that -- in fact, tomorrow we'll
22 be filming some PSA's about drug-to-driving. So the

1 more we bring that to people's attention, that this is
2 a significant issue and the fact that so much of it
3 was not known because the labs don't test,
4 particularly when it's both alcohol and drugs. I
5 think the better off we'll be and the safer we're
6 going to make our roadways. I mean, you don't really
7 have to be a Ph.D. not to say, don't operate your
8 computer while you're driving your car. I mean, it
9 seems to me a message that resonates well, we
10 shouldn't be doing drugs and getting behind the wheel.

11 Chairperson Hyde: Other comments?

12 Mr. Kerlikowske: Sorry for all the Ph.D.'s,
13 there's just a plethora.

14 [Laughter.]

15 Chairperson Hyde: Are there other comments
16 from the council?

17 Yes, Cynthia.

18 Ms. Wainscott: Cynthia Wainscott from
19 Atlanta. I would like to congratulate you on clear
20 goals that can be measured. That took a lot of nerve,
21 but that's the way we'll get it done.

22 Mr. Kerlikowske: I think so to. I don't

1 think we shy away from being held accountable and for
2 measuring on those goals. We also think it is
3 probably important to go after the things, not just
4 the number of kids who can abstain from marijuana or
5 softening attitudes. Those are important, but when I
6 think of the drug driving -- drunk driving, when I
7 think of the loss of life due to the drug overdoses,
8 those are things we can actually make a difference.

9 You know, when I got the job, a lot of
10 people -- you get a lot of advice from a lot of
11 people, and they said the work you did and however
12 long you're privileged the position, you could look
13 back after three years, four years, whatever it
14 happens to be, and look back and say, "Well, what did
15 you accomplish?" And you say, "Well, let's see, I got
16 300,000 frequent flier miles, and I got a million
17 Hilton points, and I gave 400 speeches and whatever."
18 They said, "Set aside some goals and think of some
19 things you want to do regardless of how hard they work
20 you on everything else, that you want to leave at the
21 end of your time of this." And so, we set aside those
22 three signature goals, overdoses, fatal overdoses,

1 reducing that prescription in the prescription drug,
2 in the prescription drug issue, drug-to-driving, and
3 then I thought about the other, and I thought, who's
4 the redheaded stepchild in the room, and it's
5 prevention.

6 Prevention does not get the attention or the
7 focus or the recognition that it should, and we would
8 all be so much better if we figured out that by
9 delivering those messages, and Pam mentioned that when
10 she said, "What's the one thing that you could
11 deliver?" If we consistently hit kids with -- hit
12 them messages -- hit them with messages from their
13 parents, from the school, from their faith leaders,
14 from the community, about making good choices, whether
15 it's good choices not to smoke, not to do drugs, not
16 to be an underaged drinker, and to make healthy
17 choices when it comes to exercise and eating.

18 Kids actually will accept those messages,
19 learn from them, and they can be -- I think the most
20 meta-analysis of all of that could be actually quite
21 successful. How foolish of us to think that eight
22 hours, eight one hour sessions in the fifth grade at a

1 DARE program and eight one hour sessions in the eighth
2 grade are like some inoculation. And now when this
3 kid hits the 12th grade, that oh well, I remember that
4 from eighth grade and I won't do that. It has to be
5 consistent, it has to be clear, it has to be a
6 retirement, it has to be from respected messengers.
7 And you all know that better than anyone else. And I
8 applaud your work, I applaud SAMHSA and Pam and the
9 strategic initiatives, and we pair so closely with
10 what you're doing that there is no daylight between
11 us.

12 Thank you.

13 [Applause.]

14 Chairperson Hyde: Thanks, thanks, Gil. You
15 see why we do well together. Thank you for coming
16 out.

17 I think this concludes it and we stand
18 adjourned. We'll let you go together. All right.

19 [Adjourned at 6:20 p.m.]

20

21

22