

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

42nd Meeting

Tuesday,
September 11, 2007

Sugarloaf Mountain and Seneca Rooms
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, Maryland

IN ATTENDANCE:

Chairperson

Terry L. Cline, Ph.D.
Chair/Administrator
Substance Abuse and Mental Health Services Administration
Rockville, MD 20857

Executive Director

Daryl W. Kade, M.A.
Executive Director, SAMHSA National Advisory Council
Associate Administrator for Policy, Planning,
and Budget, SAMHSA
Rockville, MD 20857

Executive Secretary

Toian Vaughn, M.S.W.
Executive Secretary, SAMHSA National Advisory Council
Rockville, MD 20857

Members

James R. Aiona, Jr.
Lieutenant Governor
Executive Chamber
Hawaii State Capital
Honolulu, HI

Gwynneth A.E. Dieter
Mental Health Advocate
U.S. Embassy Belize

Faye Annette Gary, Ed.D., R.N.
Professor, Case Western Reserve University
Frances Payne Bolton School of Nursing
Cleveland, OH

Diane Holder
President
UPMC Health Plan
Pittsburgh, PA

Barbara Huff
Consultant
The Federation of Families for Children's Mental Health
Wichita, KS

IN ATTENDANCE:

Kenneth D. Stark
Director, Mental Health Transformation Project
Office of the Governor
Olympia, WA

Kathleen Sullivan
Journalist
Rancho Mirage, CA

Ex Officio Members

Laurent S. Lehmann, M.D.
Chief Consultant for Mental Health
Department of Veterans Affairs
Washington, D.C.

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1 P R O C E E D I N G S (9:02 a.m.)

2 DR. CLINE: Good morning, everyone. I'd like
3 to call the meeting to order. It sounds like there are
4 some very interesting conversations taking place around the
5 table. I hate to interrupt those, and maybe we can just
6 put those on hold for a while.

7 Welcome back to the second day of the National
8 Advisory Council meeting. I'd like to welcome you all
9 back. We had, I think, a very interesting day yesterday
10 with a wealth of information and a wealth of discussion
11 from the council.

12 What I'd like to do this morning, you'll see
13 from your agenda that we have our roundtable discussion.
14 We have about 15 minutes allocated to really summarize some
15 of the recommendations that emerged from the council
16 yesterday, and staff worked to pull together all of the
17 comments, and we are going to present those in kind of a
18 summary form in the form of a statement. We'll do our best
19 to kind of type that statement up and modify it and clean
20 it up a little bit as we go along, and then to see if we
21 can come to consensus on those recommendations, basically
22 one from each of the areas that we discussed yesterday.

23 Then after that we will move into the rest of
24 the agenda, which is really focused on Science to Service
25 initiative. Dr. Hennessy will be leading us through that

1 process. We'll be starting by recognizing some people who
2 have been recognized for their outstanding work in this
3 area who have come from across the country. So we'll
4 recognize them with awards and then follow that with
5 individual presentations from five of those which are
6 really representative of a larger group of people who have
7 received awards from SAMHSA for their outstanding work,
8 moving science into practice in the field.

9 But let's start with a bit of a recap of some
10 of the work that took place yesterday. The first area was
11 really in the area of suicide prevention. So I'm just
12 going to walk through this a little bit and we'll try to
13 place it up there in written form. These are all the
14 individual comments that emerged, and now we're going to
15 try to pull that together in summary format, not starting
16 with the fish. So let me just go ahead and start with
17 this.

18 Council identified the need for integrated,
19 cross-system gatekeeper training to identify risk factors
20 and do early screening and referrals in suicide prevention.

21 These gatekeeper activities should include locations such
22 as churches and beauty shops, Salvation Army and workplace.

23 That really captured the essence of all of the comments
24 that we heard from the council. So just to recap that, and
25 again, we'll frame that so you can actually see it, council

1 identified the need for integrated, cross-system gatekeeper
2 training to identify risk factors and do early screening
3 and referrals in suicide prevention, and these gatekeeper
4 activities should take place in locations such as churches
5 and beauty shops, Salvation Army and workplaces.

6 There were other suggestions and there are some
7 follow-up items, and for those of you who requested
8 individual information, we'll make sure that that
9 information gets to you.

10 Ken?

11 MR. STARK: Terry, the addition that I would
12 ask to make to that would be I think we also talked about
13 doing those screenings in schools, as well as health
14 clinics.

15 DR. CLINE: Yes, and that's why I said "in
16 locations such as." Those are just examples, and the
17 essence of that again is to really broaden the scope of
18 those activities so we're not just in health clinics, we're
19 not just in hospitals, we're really a much broader array.

20 MR. STARK: Well, the only reason I mention
21 that is because if we don't mention health clinics and
22 schools in there, especially given the push we're all
23 trying to make nationally to impact those systems, my
24 theory is that it just won't get attention.

25 DR. CLINE: Yes, and we can include any of

1 those that the council wants to include. I just want to
2 make it clear that it's not an exhaustive list.

3 PARTICIPANT: Can you read that again?

4 DR. CLINE: Sure, one more time. The council
5 identified the need for integrated, cross-system gatekeeper
6 training to identify risk factors and do early screening
7 and referrals in suicide prevention. So that's the first
8 part. The gatekeeper activities should take place in
9 locations such as churches, beauty shops, Salvation Army,
10 health clinics, schools, and workplaces. Basically, we're
11 taking that first one there and including that.

12 Any questions about that one? We'll get the
13 follow-up language. Yes, Ms. Dieter? If you could use
14 your microphone.

15 MS. DIETER: We talked about trying to push to
16 integrate training into higher education, but we don't want
17 to -- is that implied in this statement?

18 DR. CLINE: Again, we could continue on with
19 the list of places to include there, and if you would like
20 to make special note of that, then we'll include that,
21 higher ed, in terms of one of the locations.

22 MS. DIETER: Yes.

23 MR. STARK: Are you done?

24 MS. DIETER: Yes.

25 MR. STARK: The other thing, when I mentioned

1 my comment yesterday, was the integration was really
2 looking at trying to integrate alcohol, drug screening and
3 mental health screening, and suicide risk screening all in
4 one integrated process, and I'm not sure that that
5 statement captures that.

6 DR. CLINE: Okay. So let's make sure that
7 we're clarifying really what we mean by "integrated" and
8 that it includes those components.

9 MR. STARK: That it includes alcohol, drugs,
10 mental health, including suicide.

11 DR. CLINE: Right.

12 MR. STARK: Good.

13 DR. CLINE: And then the one piece we would add
14 is -- and we can put it as a comma -- "integrated," in the
15 first sentence, about the fifth word back, to include, Ken,
16 all those pieces?

17 MR. STARK: Alcohol, drug, and mental health,
18 including suicide.

19 DR. CLINE: Okay, and then we'll just insert
20 that up by the integrated piece of that.

21 Okay. Is there general consensus with that
22 statement? And we'll clean that up, of course. That's
23 rough, but I want to make sure we have the primary
24 elements.

25 Ms. Dieter, we can add the higher education

1 piece as one of the locations. Would that capture it if
2 it's there?

3 MS. DIETER: I'm not sure. I'll leave that up
4 to you whether it's necessary. I would just simply make
5 sure that you have the schools and health centers first in
6 that list of such locations, because they would be of
7 primary importance. Oh, you have it now, schools, churches
8 -- schools and health centers, then churches.

9 DR. CLINE: Again, there are those points that
10 we want to make absolutely certain are included, but this
11 is not meant to be an all-inclusive list. But we'll be
12 certain to highlight those points, okay? All right. Thank
13 you.

14 For workforce development, there really were
15 not any specific recommendations that emerged. There was
16 recognition that there was great opportunity to harness the
17 peer and family support services, and that that also would
18 in some ways mitigate the cost of chronic health care, and
19 also the emphasis and the importance and value associated
20 with work itself to the entire process for individuals who
21 are in recovery, and the importance of that role. So those
22 were two points that were made but were not actually
23 recommendations.

24 Dr. Gary?

25 DR. GARY: Those points were made, and I think

1 when Ms. Power did her presentation, she certainly focused
2 on the need for workforce in a different way because she
3 was thinking about issues regarding the military and the
4 looming mental and physical health problems. So I'd like
5 to make a recommendation about the workforce.

6 In our previous meetings we had made comments
7 such as that workforce underpins all of the other kinds of
8 priorities and principles, because you have to have a
9 viable workforce in order to address any of the other
10 issues that we would wish to address. So I'd like to
11 venture a recommendation and also commend SAMHSA for its
12 focus on workforce, but to understand that if we're talking
13 about quality of care, if we're talking about generating
14 science and translating it to service, we must have a
15 viable workforce, and it must be much more diverse than it
16 is now. I think that was one of the comments that Ms.
17 Power made yesterday as well.

18 DR. CLINE: Okay. Just to get a read from the
19 rest of the council, it sounds like in essence what you're
20 recommending is that we make a statement that acknowledges
21 the value, the importance of that as an underpinning for
22 all the work that we do, more foundational.

23 Yes?

24 MS. HUFF: Kathryn, Georgetown University has
25 done a whole lot of work around workforce development. It

1 seems like we ought to be looking at what's already been
2 done. Much of your money has already been spent on looking
3 at that, at least in the mental health arena, because I was
4 on a committee or two before I moved, and they divided into
5 some subcommittees, and they have really done a very
6 comprehensive look at and made huge recommendations around
7 workforce development. I'd really like to see us gather
8 that material because I have very strong feelings about
9 workforce development as it relates to the kind of
10 training, and it's huge in rural areas, how we get the
11 workforce out there and trained and the kinds of incentives
12 that need to happen to do that. But that's already been
13 looked at, and I don't feel like we have to re-hash that,
14 but I do feel like it needs to come to the surface again.

15 MS. POWER: I think that we didn't have a
16 chance yesterday to really talk about some of the work that
17 the workforce development matrix is doing, which really
18 combines some of the comments here. I think the intent
19 yesterday was to really focus in on Larry's message
20 relative to the incorporating and inclusion of individuals
21 in recovery in the workforce. But there's a whole other
22 set of work that's going on. Kevin is certainly a part of
23 that as part of the staff, and all of the matrix area. We
24 are inventorying all of that kind of work and bringing that
25 to bear, along with all of the Annapolis Coalition work and

1 the Addiction Professionals work, some of our TA providers
2 that have done some workforce, and we're currently involved
3 in inventorying that. That, I think, will help inform the
4 Administrator about next steps relative to some of the
5 other strategic issues in workforce, and I think, Faye, we
6 will pick up some of the other pieces relative to how does
7 that help us support the VA and DOD within their workforce
8 issues relative to behavioral health. So we're hoping that
9 that will happen.

10 MS. HUFF: Do you need a recommendation on
11 that?

12 DR. CLINE: That's something that we're already
13 doing. That's what Kathryn is acknowledging, that what you
14 saw yesterday was a drop in the ocean of work that has been
15 done in this area, pulling that together.

16 MS. HUFF: I felt like we were kind of passing
17 by a huge issue. They're already working on it. I know
18 that.

19 DR. CLINE: You're giving us a good opportunity
20 to really highlight all of that work, which has been months
21 in the making, so pulling that information together. Thank
22 you.

23 Ken?

24 MR. STARK: Yesterday in Larry's presentation,
25 what was inherent, for me anyway, when he talked about the

1 use of consumer and family-run services and consumer
2 members and family members as the people who provide those
3 services, was the whole idea of if we have a workforce
4 shortage among professionals, then we really need to
5 reevaluate what is it that we're using the professionals to
6 do, what services are they providing, and do we really need
7 that level of education and training to provide that level
8 of service, and should we not reevaluate and establish a
9 level of service with levels of competencies that may or
10 may not have anything to do with degrees but rather
11 competency training. That's where we can bring in a lot of
12 consumers and families to fill voids where we don't need
13 Ph.D.s or M.D.s or M.S.W.s and still get very effective
14 services with very targeted training using consumer and
15 family-run services. That's really what, to me, was
16 inherent behind Larry's recommendations as part of helping
17 with the whole workforce shortage issue.

18 MS. POWER: And I think that's one of the
19 reasons that we have focused in our discussions
20 strategically on that core competency area, Ken. We know
21 we have already established core competencies in substance
22 abuse and addictions. We need to develop some in mental
23 health. But the peer support issue that Larry raised is
24 another whole set of competencies and a whole other skill
25 level that we need to acknowledge and look at relative to

1 the overall strategy. So I think that's a very important
2 observation and one that we're working with.

3 DR. CLINE: Ms. Dieter?

4 MS. DIETER: I'm glad you said this, Ken,
5 because at our previous meeting my perception was that we
6 had emphasized -- and it sounds like that's what is going
7 on, although I wasn't totally clear on that yesterday
8 because we just had a little piece -- to look at workforce
9 development in a new way, a new paradigm, particularly as
10 we looked at the problem and lack of professionals in rural
11 areas and so forth, how can we use other people and do that
12 sort of thing, and it just appears to me that we want to
13 continue to emphasize that because it has such potential
14 and can happen and will probably happen. So I think
15 somehow, perhaps in our summary, that could be once again
16 encapsulated in our comment that we're all in favor of that
17 new look.

18 DR. CLINE: So maybe something along the lines
19 of the council supports the exploration and development of
20 core competencies and peer support services in furthering
21 the workforce development of the field, which would cover
22 substance abuse and mental health.

23 Ken?

24 MR. STARK: And I know SAMHSA is already
25 looking at all of these issues, and they need to be looked

1 at, but if I could just take a second and sort of read a
2 list. When I think about workforce development, the issues
3 that come up for me are things including reduced
4 administrative and regulatory barriers, and that payers and
5 government entities need to look at that as one of the
6 things related to workforce development; improved clinical
7 supervision, which did come up yesterday; increasing the
8 kinds of billable services, which may include some of the
9 administrative services, because again we have a lot of
10 work that we require of folks both relative to paperwork as
11 well as outreach and a number of other activities that many
12 times we don't pay for. Then there are issues about
13 adequate salaries and benefits, and that ties to issues of
14 rate structures, and that ties to issues of core
15 competencies and training.

16 There is the issue we just talked about
17 relative to sort of layering, using the right people for
18 the right job and not having over-qualified people do
19 certain jobs, which then costs more money than need be, or
20 under-qualified people doing jobs. There's the whole issue
21 of even when we get M.S.W.s and psychologists and sometimes
22 physicians, and they come out of these training programs
23 and schools, they have to be retrained when they get to the
24 field because the higher education systems aren't training
25 people in practical application of evidence-based

1 practices. So it seems to me that even though we don't
2 control and can't control higher education, we can
3 certainly make recommendations that higher education for
4 people that are going into clinical work need to be trained
5 as part of their degree programs in practical applications
6 of evidence-based practices so when they come out we don't
7 have to retrain them. That becomes a big issue.

8 There are the issues of expanding prescriptive
9 authority, which some states have done. If you have a
10 shortage of professionals who have prescriptive authority,
11 there are states who have expanded it beyond psychiatrists
12 and physicians and looked at even psychologists having
13 certain prescriptive authority.

14 Then there's the issue of the peer and family
15 services that we just talked about; and then, of course,
16 the one we can't forget about is the increased use of
17 technology, particularly telehealth kinds of activities for
18 rural communities as a way to deal with workforce
19 development.

20 So that's sort of the broad perspective that I
21 think about when I think about workforce development.

22 DR. CLINE: And with the possible exception of
23 the prescription authority, I think that all of those
24 elements are included in the workforce development strategy
25 that we have here at SAMHSA.

1 MR. STARK: They are.

2 DR. CLINE: And I don't know if council members
3 have actually seen that document. Do you know, Kathryn?

4 MS. POWER: If the members have?

5 DR. CLINE: Yes.

6 MS. POWER: No.

7 DR. CLINE: Okay. One of the things we might
8 do, then, is follow up and provide that to you so that
9 you'll have that just as a reference, so you'll have a
10 sense that indeed those things are included there.

11 Yes, Dr. Gary?

12 DR. GARY: I just want to follow up on one of
13 the comments that Ken made, and that is the billing
14 structure. I think we also need to recognize that the
15 billing structure will dictate the roles and functions of
16 mental health providers, and I think we need to think about
17 that and to know that the billing structure produces a
18 certain remuneration for a certain kind of service that
19 perhaps could be given by numerous different professionals,
20 but it may not. So what happens in terms of patient care
21 is that the patient care is directly affected by the
22 billing structure of the patient.

23 I'll give you an example, and maybe Dr. Lehmann
24 can further elucidate. When I was trained, I was trained
25 where we really paid particular attention to the

1 psychotropic medications, to physiological effects of the
2 medication on the patient, as well as providing the
3 therapy, individual therapy. Family/group was done in a
4 team, and we had a comprehensive sense of what was going on
5 with the patient and family. But given the billing
6 structure where we have those individuals who can do
7 medication checks and write prescriptions for medications,
8 their billing is about two or three times the amount that
9 one would get for doing the individual therapies, the
10 support therapies, the follow-through, et cetera. So that
11 has quietly restructured the way that people get care, and
12 I don't think it's always to the benefit of the patient,
13 the family, and the community.

14 DR. CLINE: Any other comments?

15 (No response.)

16 DR. CLINE: Okay. We'll move to the next
17 section, which is the Helping America's Youth Initiative.
18 Again, we had many comments, and I have summarized those as
19 well, so let me just run through this, that the council
20 recommends that SAMHSA needs to hold focus groups to
21 include the target audience, whether those are youth or
22 other people using the services, to tailor the effort by
23 modality, appeal, whatever might appeal to that particular
24 group, the use of common mechanisms, and that they also
25 enlist experts from the private sector outside of the

1 federal government; again, trying to keep that broad and
2 realizing that it's not all-inclusive, whether it's AOL or
3 Google or whoever that might be.

4 The intent in grouping that together was that
5 if the HAY group -- and we have Larke here with us -- is
6 wanting to target youth, then they need to make sure that
7 they're including youth in those focus groups. We have a
8 sense of what mechanisms those particular groups are using
9 in their day to day life. Where do they go? What websites
10 do they use? What modalities do they use? And are we
11 really using what they use? Rather than trying to match
12 our system to theirs, how can we capitalize on what's
13 currently being used by the target audience? Again, this
14 gets back to the approach of the best way to find out how
15 to reach certain groups is to actually include them in the
16 process and to make certain that we're tailoring those
17 efforts to the needs that are expressed by those particular
18 groups.

19 So the intent was to capture that with that
20 comment. There were many, many comments that were made,
21 and I think that most of those are incorporated into that
22 particular statement.

23 Yes?

24 MS. SULLIVAN: Graphic. I mean, I think the
25 website is inaccessible. It doesn't look -- I don't want

1 to go there. It looks all provider oriented and not
2 consumer oriented.

3 DR. CLINE: And I think this is part of the use
4 of common mechanisms that are user friendly. So again,
5 that target audience for providers, the mechanism used for
6 providers will look very different than the mechanism that
7 we hope youth will access, and acronyms may be used in one
8 and not used in the other. All those things need to be
9 tailored to the target audience.

10 DR. GARY: I would just like that we put in the
11 statement that we will also provide it in different
12 languages and that they will be culturally sensitive to all
13 individuals in society.

14 MR. STARK: (Inaudible.)

15 DR. GARY: I think it needs to be in the
16 statement, though, that we need to have it in Spanish and
17 whatever.

18 DR. CLINE: Okay. We'll make certain to
19 include that.

20 MS. HUFF: Do these words encompass what we
21 talked about as it relates to kids who don't have immediate
22 access to computers and that sort of thing?

23 DR. CLINE: Well, that is the intent in talking
24 about common mechanisms and modalities, that although the
25 presentation was really focused on the website, that may

1 not be the modality that reaches all of the intended
2 targets. Then again, the folks who are organizing this
3 from the HAY Initiative may decide they simply can't do it
4 all, but they need to be purposeful and follow that in a
5 thoughtful manner, that if they're excluding certain
6 groups, then they need to be thoughtful about that and not
7 do it simply through omission.

8 MS. HUFF: Okay. I just want to make sure that
9 those words really mean what we said. Did you get that?
10 Do you think it does? I'm afraid if we weren't here,
11 nobody else would know what that meant.

12 DR. CLINE: We can, as part of our
13 wordsmithing, we can strengthen that. Again, the point
14 that I want to make with it is that we're pulling those
15 concepts together rather than, again, trying to be
16 exhaustive. There were a lot of ideas that were generated
17 yesterday, so for some of those we may need to rely on
18 those broader concepts rather than trying to be
19 all-inclusive with that.

20 MS. HUFF: And I realize that. It's just that
21 if I looked at that and hadn't been in on the conversation
22 yesterday, I wouldn't have the foggiest idea.

23 DR. CLINE: And again, part of this is the
24 advisory council advising us who are participating --

25 MS. HUFF: I'm making my last stand today.

1 (Laughter.)

2 DR. CLINE: Now, if that was a guarantee,
3 Barbara --

4 (Laughter.)

5 DR. CLINE: I'm not buying that.

6 (Laughter.)

7 DR. CLINE: There will be many, many more
8 opportunities. Many, many more.

9 MS. HUFF: But you know what I mean.

10 DR. CLINE: I do know what you mean. If you're
11 in agreement with the concept, then we will again do some
12 wordsmithing and make sure that that gets back to you all,
13 and if there are things that you would like to add or
14 change with that, then we can do that on an individual
15 basis, too.

16 Ms. Dieter, and then Ken.

17 MS. DIETER: Yes, I agree with Barbara a bit.
18 I mean, I look at the brochure on this initiative, "It's a
19 challenge to motivate caring adults to connect with youth."
20 So the goal here is to have a caring adult in your school,
21 community, family connect with a person at risk in hopes
22 that then they lead a healthier, happier life. I guess the
23 website is part of the initiative, MapIt. I just think the
24 website is going to miss probably the biggest portion of
25 the kids who are in need, and the adults in that community.

1 For example, my first thought is that although
2 many poor young people don't have access to computers, or
3 even if they have them in school may not access them, it
4 seems to me that most people today watch television or have
5 television. So again, I go back to maybe you do
6 advertisements. I don't know about the expense and how all
7 that works. I don't know this, but I believe most poor
8 people watch television, have television. So there is a
9 channel or other means of doing this. Besides making the
10 website user friendly, are we focused too much on the
11 website as the access for this? I guess that's my
12 question.

13 DR. CLINE: I'm actually going to turn to Larke
14 for part of this response. Having participated in two of
15 the HAY Initiative meetings, and although probably 95
16 percent of our conversation has focused on kind of the
17 youth involvement piece of this, my understanding is that a
18 large focus for the initiative is actually targeting the
19 adults and the adults becoming more involved in children's
20 lives, and that has been, I think, most of the focus. But
21 I'm just going to ask for clarification while we have the
22 expert. If you could just move to the table, whichever.

23 DR. HUANG: Well, I appreciate these comments.
24 I think I might have misled you yesterday when I was
25 talking about the portal on youth. I think people thought

1 it was a portal for youth, so I think you were focused on
2 youth as the primary users. The primary users are not
3 exclusively youth. It's really caregivers, caretakers,
4 providers, schools, adults who are trying to encourage to
5 develop these connections with youth. So youth is one
6 piece of it, and the portal on youth was really an attempt
7 to bring together all federal resources, information about
8 funding, information about programs across the 10 agencies,
9 initiatives, all of what we each have collected in terms of
10 best practices, and put it in a one-stop website where it's
11 a portal. So it wasn't just youth.

12 Now, I should say that part of the initiative
13 is this online community guide, which I agree with your
14 comments about making it more graphic, more accessible.
15 Even for adults, it's not the most accessible or appealing
16 at this point. In some ways, we're trying to work with 10
17 different agencies' perspectives on what they want it to
18 be. So we're still in development around that.

19 But another piece of the initiative are these
20 regional meetings which are done in small groups of states,
21 and it is through those meetings that we really try to
22 reach across population groups. For example, when we were
23 in Colorado, we made a big effort to reach Native American
24 populations. So our presenters at that meeting, the
25 coalitions and the community leaders we were trying to pull

1 in were really driven by needs of Native American
2 populations. So we really are trying to do more outreach
3 around the regional meetings to bring people in to use the
4 guide and use some of the strategies and some of the
5 programs in the guide.

6 So that's one effort. I do agree that we need
7 to do better outreach in terms of some of the focus groups
8 from different populations, what would they want to see on
9 that website and in the guide. So there are multiple
10 thrusts we have around this. I hope that clarifies it a
11 little.

12 MS. DIETER: Thank you. It does a lot. I
13 actually think it's great that you put all this information
14 together. I mean, it's invaluable to have it done. I'm
15 sort of jumping to the next step. Here you've worked and
16 accomplished this thing, and I couldn't quite see where the
17 actual practical coming together of the adult and the young
18 person is going to take place or where the thrust is. Now
19 I've just learned about the regional outreach meetings.
20 That's one thing, and I'm just thinking in my head how you
21 would try to have these people connected and through what
22 means.

23 DR. HUANG: We're keeping track of them so that
24 we have, through the regional meetings, sort of a database
25 of people who have been involved in it so we can continue

1 to use them to further outreach and expand, sort of
2 multiply our impact through the regional meetings. Okay?

3 MS. DIETER: Okay. Thank you.

4 DR. CLINE: We'll move to Kathleen and then to
5 Ken, and then we'll need to move on.

6 MS. SULLIVAN: Larke, if we're going away from
7 the student and this is an adult-accessible site, shouldn't
8 we also include in our verbiage today teachers, the
9 mentoring network, some of the really broad focus groups
10 reflected in our statement, do you think? I mean, we're
11 not reflecting any specific group such as --

12 DR. HUANG: It sounded to me in your statement
13 that you wanted -- who we targeted is end users, for us to
14 do focus groups on those.

15 MS. SULLIVAN: I think we need to specify end
16 user because, I've got to tell you, it's driving me crazy,
17 all this lingo. I mean, we've just got to start speaking
18 English here.

19 DR. HUANG: I actually would appreciate if you
20 delineated that, because we actually have a work group
21 tomorrow. So if I can go back and say these are some of
22 the groups that were delineated by our advisory council to
23 be included in focus groups, that would certainly help in
24 our discussions.

25 MS. SULLIVAN: Mentors, the mentoring network

1 that's already there, and maybe also something that goes to
2 the counselors at the Boys and Girls Clubs. This is in the
3 realm of people who do the after-school sports. I have to
4 tell you, the USTA, the United States Tennis Association,
5 has a very strong youth program. So does the USGA. These
6 are people who work with kids all afternoon, and this is
7 exactly what they need, something that's out of the purview
8 of the organization, and maybe it's Girl Scouts, Boy
9 Scouts. It's these people in the afternoon, as far as my
10 mind set is.

11 DR. HUANG: Okay, great.

12 DR. CLINE: Ken?

13 MR. STARK: Larke, I do remember yesterday when
14 you talked about the website and it was discussed that it
15 wasn't just for youth, because I remember one of the
16 discussions that came out, and one of the comments that I
17 made was that if I were to use it and I were a government
18 employee or I were a provider and looking at wanting to
19 have youth input into our process, that if I used the
20 website I'd need to know how I could make contact with
21 organizations that were involved with youth that might
22 provide a representative in our area.

23 So to me, the key point that came out of that
24 discussion was making sure that whoever is sort of listed
25 on that website, that there needs to be contact information

1 for those individuals or those organizations so anybody
2 going on the website can make contact with those folks to
3 follow up with.

4 I'd also like to make one other comment. I
5 hope the minutes reflect that Barbara is making her last
6 stand today, and Kathleen is refusing to leave.

7 (Laughter.)

8 DR. CLINE: So we will work to incorporate
9 those comments. I appreciate that. Mark, thank you.

10 DR. HUANG: We will provide the contact
11 information, too. Thanks.

12 MS. HUFF: Can I add one more thing to that
13 list? PTAs. I think it's pretty white and middle class
14 for me to be talking about, but they still do carry some
15 weight. I mean, nationally they do.

16 MS. SULLIVAN: Did you also check school
17 districts on there? I mean, the general school district
18 supervisor, anyone who comes into contact with kids in a
19 day.

20 DR. CLINE: The list is huge, it really is.

21 MS. SULLIVAN: Right, but here's the
22 cross-reference for a second. This is where maybe we need
23 to put some money into getting this site on their site. So
24 we're going to have to ask them -- like put a little button
25 with a hyperlink for at-risk or whatever and put it on the

1 Boy Scout list, the USTA list. I mean, USTA is right up
2 there if you go to the tennis list. The USGA, all of these
3 organizations do want to help, but they don't know how and
4 they don't know the information, and I think they'd be very
5 open to seeing that. It's a tough list, but I think if you
6 contacted them, these people would really put your
7 hyperlink on their website, front page.

8 DR. CLINE: Thank you.

9 Okay. The last category is meeting the needs
10 of returning veterans and their families, and this one is a
11 little bit longer in an attempt to be more inclusive of the
12 comments. It identifies the need to provide the entire
13 continuum of services, including prevention prior to
14 deployment and family-focused education prior to
15 re-integration, as well as services in under-served areas
16 such as services to military women, services in rural
17 areas, and services to families.

18 There's one more sentence, two more sentences.

19 Services need to be culturally competent, which includes
20 the military culture, and should also be attuned to
21 domestic violence. Appreciation for the term
22 "psychological health," as opposed to "mental health," was
23 noted by the council repeatedly.

24 So we need to provide the entire continuum of
25 services, including prevention prior to deployment and

1 family-focused education prior to re-integration, as well
2 as services in under-served areas, such as services to
3 military women, services in rural areas, and services to
4 families. Services need to be culturally competent, which
5 includes the military culture, and should also be attuned
6 to domestic violence. Appreciation for the term
7 "psychological health," as opposed to "mental health," was
8 noted repeatedly by the council.

9 MS. POWER: Terry, can I just add that I think
10 it's important that when the council is making statements
11 such as "we believe" or "we want to ensure," that I
12 strengthen the comment that I made yesterday, that anything
13 that SAMHSA does is in partnership with the Department of
14 Defense and with the Veterans Administration so that their
15 roles and missions are very clear and our role and mission
16 is to support them in their efforts in both DOD and VA.

17 DR. CLINE: Thank you.

18 Yes?

19 DR. LEHMANN: One of the issues we talked about
20 was enhancing the ability of community providers to provide
21 these services. That would be good to add in. In
22 particular, I'm thinking about the families of deployed
23 reservists who don't have the support that the active duty
24 and even the National Guard folks have.

25 DR. CLINE: And I see several head shakes, so

1 let's include in supporting and enhancing community-based
2 services, especially in regard to reservists and National
3 Guard.

4 Ken?

5 MR. STARK: And I might add to that, in
6 particular in those communities where the Veterans
7 Administration does not have adequate services available,
8 which would include a number of rural communities and that
9 sort of thing, because that was much of the discussion
10 yesterday, that if you're a military person, even if you're
11 eligible for services, if you live far away from an area
12 where those services are available but there are other
13 community services available, how might the non-military
14 system and the military system work together to ensure that
15 military folks get access to services they need whether
16 they're National Guard, reservists, or active? That should
17 be VA and DOD, because they can probably help the families
18 better than VA.

19 DR. CLINE: We have them both listed there.

20 Dr. Gary?

21 DR. GARY: Just a very quick one, I think
22 identify the needs to provide services including prevention
23 prior to deployment, I think we need to add families in
24 there, because I think the families need to be involved in
25 the prevention prior to deployment, as well as the

1 reintegration. The families need to have some sense of
2 what's going on and be a part of the orientation process.

3 DR. CLINE: Other comments?

4 (No response.)

5 DR. CLINE: Okay. Well, thank you all very
6 much. We'll make certain in the future to have a little
7 more time for this part because this is important in terms
8 of that synthesis of all the information.

9 Dr. Gary?

10 DR. GARY: There was one item that we did not
11 discuss yesterday but we have typically discussed in the
12 past, and that is issues regarding the rehabilitation of
13 the lives of people who were affected by Hurricane Katrina.

14 So I would hope that we could just have a word or two
15 about an update regarding SAMHSA's role and Katrina and how
16 those programs are going.

17 DR. CLINE: I think that we can log that as a
18 request, as we're getting in the habit of doing of trying
19 to get topics from you all for future agenda items. So I'd
20 like to log that as a suggestion for a future agenda item
21 rather than trying to integrate it.

22 DR. GARY: I did not want us to leave today
23 without acknowledging that we still have much work to do
24 related to Katrina as well.

25 DR. CLINE: Okay. Thank you.

1 Actually, right now, the federal government has
2 within this hour recognized and asked us to take a moment
3 of silence in recognition of the victims of 9/11. So I'm
4 going to ask if we at this particular time would take just
5 a few moments to keep all of the families and everyone who
6 is affected, has been and continues to be affected by 9/11,
7 just to take a few moments of silence to keep them in our
8 thoughts and prayers.

9 (Moment of silence observed.)

10 DR. CLINE: Thank you.

11 At this point we will turn the agenda over to
12 Dr. Kevin Hennessy, who is in charge of the Science to
13 Service initiative here at SAMHSA, which is I think
14 entering into an especially exciting phase of development.

15 Kevin has really been the architect of this work, along
16 with many co-conspirators, but I would like to turn it over
17 to him right now.

18 Kevin?

19 DR. HENNESSY: Thank you, Dr. Cline.

20 Several years ago, SAMHSA established a Science
21 to Service initiative with the overarching goal of reducing
22 the lag time between the development and the testing of
23 interventions to prevent and to treat mental and substance
24 use disorders, and the broader dissemination and
25 implementation of these interventions in community

1 settings. As most of you know, the process of that
2 translation can take anywhere from 15 to 20 years.
3 Increasingly we're realizing that most of the lag time is
4 associated with the uptake of proven or evidence-based
5 interventions within routine clinical and community-based
6 settings. That's why the efforts of the organizations that
7 are represented here and that we'll be introducing soon are
8 so notable and so worthy of recognition. The purpose of
9 the Science to Service Awards that we're honoring today is
10 to provide visible and national recognition to
11 community-based organizations and coalitions that have
12 successfully implemented one or more recognized
13 evidence-based interventions to benefit consumers and
14 communities.

15 For the inaugural 2007 awards, the agency
16 received a total of 115 applications, and from this pool 20
17 organizations were selected for recognition.
18 Representatives from five of these 20 organizations are
19 present with us today, one organization from each of the
20 five award categories: mental health promotion, treatment
21 of mental illness and recovery support services, substance
22 abuse prevention, treatment of substance abuse and recovery
23 support services, and co-occurring disorders.

24 Representatives from the remaining 15 award
25 organizations will participate in similar panels over the

1 next six months at one of three National Advisory Council
2 meetings for SAMHSA's three centers. All 20 award winners
3 have been identified in a SAMHSA press release issued
4 yesterday. In addition, brief summaries of organizational
5 contacts on all the award winners are available through a
6 new Science to Service Awards page, a webpage, that is
7 actually available through SAMHSA's website.

8 Dr. Cline, without further ado, I hope that we
9 can recognize and honor these new Science to Service Award
10 winners.

11 DR. CLINE: Okay.

12 DR. HENNESSY: When you hear your organization
13 announced, if you can come up to receive your award.

14 Our first organization is King County Mental
15 Health Chemical Abuse and Dependency Services Division from
16 Seattle, Washington. King County is receiving an award in
17 the treatment of substance abuse and recovery support
18 services category for implementing Global Appraisal of
19 Individual Needs. Accepting the award for King County is
20 Jim Vollendroff, Assistant Division Director for Prevention
21 and Treatment Coordinator.

22 (Applause.)

23 DR. HENNESSY: Our next award winner is the
24 Maryland Department of Health and Mental Hygiene, the
25 Mental Hygiene Administration in Baltimore, Maryland.

1 They're receiving an award in the treatment of mental
2 illness and recovery support services category for
3 implementing supported employment. Receiving the award for
4 Maryland is Dr. Brian Hepburn, who is the Commissioner of
5 the Mental Hygiene Administration.

6 PARTICIPANT: And Steve Reeder and Christine
7 Johnson.

8 DR. HENNESSY: Okay. Thank you.

9 (Applause.)

10 DR. HENNESSY: Our next award winner is
11 Morrison Child and Family Services from Portland, Oregon.
12 Morrison is receiving an award in the mental health
13 promotion category for implementing the program The
14 Incredible Years. Accepting the award for Morrison is
15 Margaret MacLeod, the Director of Outpatient Services at
16 Morrison.

17 (Applause.)

18 DR. HENNESSY: Our next award goes to Santa Fe
19 Adolescent Services in Fort Worth, Texas. Santa Fe is
20 receiving an award in the substance abuse prevention
21 category for implementing the Reconnecting Youth, the
22 Strengthening Families, and the Second Step Violence
23 Prevention Programs.

24 (Applause.)

25 DR. HENNESSY: Receiving the award for Santa Fe

1 is Virginia Hoft, the Executive Director.

2 (Applause.)

3 DR. HENNESSY: And our fifth and final award
4 for today goes to Thresholds of Chicago, Illinois.
5 Thresholds is receiving an award in the co-occurring
6 disorders category for implementing integrated dual
7 disorders treatment. Receiving the award for Thresholds is
8 Dr. Timothy Devitt, the Director of the Integrated Dual
9 Disorders Treatment Practices.

10 (Applause.)

11 DR. HENNESSY: Now I would ask that the
12 representatives from each of the five organizations move up
13 to the table, and we'll have an opportunity to hear from
14 you.

15 As we noted, the challenge really is in
16 implementing these interventions in real-world settings,
17 and each of our organizations has an important story to
18 tell and has learned a great deal that might assist SAMHSA
19 and its stakeholders in how we might translate these
20 practices more effectively and more efficiently, and really
21 hopefully how we can learn and promote the uptake of these
22 practices and give the individuals that need these services
23 the best that society has to offer.

24 So with that said, we're going to hear briefly
25 from each of the five organizations, and each will have

1 about five minutes to present your information, tell us
2 your story. I would note for council that we do have I
3 guess it's about an hour left in this segment. So if there
4 are any burning questions that you have for the presenter,
5 you could certainly ask them during the midst of their
6 presentation. If not, we would ask that you hold questions
7 until the end and we'll have an opportunity to ask
8 questions at the end of the presentations.

9 So let us start with Jim Vollendroff from King
10 County.

11 MR. VOLLENDROFF: Good morning and thank you.
12 I'm pleased to be here this morning. I have five minutes
13 to tell what's been a five-year ongoing body of work that
14 continues today in Seattle, Washington, so I will keep this
15 brief. My name is Jim Vollendroff, as I've already been
16 introduced, and I'm the prevention and treatment
17 coordinator in King County, which is located in the State
18 of Washington. We're the twelfth largest county by
19 population in the country, and as such we have a large
20 provider network. My overall responsibility is to deliver
21 the substance abuse prevention and treatment services to
22 the indigent and low-income population, and as such I have
23 a provider network of 37 providers that we contract with.

24 I'm going to take you back and tell you a
25 little bit of history. I am a clinician by heart. I

1 became a bureaucrat five years ago this month, as a matter
2 of fact, and I went into the public system as a result of
3 being a provider who was frustrated around trying to
4 implement evidence-based treatment within my organization.

5 I would go to trainings and we would get excited about the
6 opportunity. We would receive the manual, we would receive
7 encouragement, and then I would go back to my organization
8 to be faced with parents in crisis, with adolescents
9 breaking furniture, and that manual would sit on my desk
10 and I would not have the time to implement what I had just
11 begun to get excited about.

12 So my mission when I went to graduate school
13 and decided I was going to get into the public arena was to
14 figure out a way to bring science to practice. So what I
15 did, we are one of the 10 Reclaiming Future sites, which is
16 a Robert Wood Johnson Foundation grant, and we were
17 fortunate enough, I was fortunate enough to be introduced
18 to some of the brightest minds in the country around
19 substance abuse. So the particular place that we started
20 was with the assessment of our adolescents. We decided
21 that we would not mandate evidence-based practices amongst
22 our provider community. Instead, we would solicit them to
23 help us choose this particular assessment tool. Providers
24 chose this particular tool, and we have worked with them
25 over the last four years to implement this, and

1 consequently now our providers, as a result of having good
2 quality data, are coming to us and now telling us what they
3 would like to implement.

4 As a result of implementing the Global
5 Appraisal of Individual Needs, which is the particular
6 assessment tool that we're using, we've now implemented the
7 seven challenges. We have MST, we have FST, we have
8 several providers now coming to us and telling us what
9 they'd like to implement.

10 Just a quick little story. Previous to
11 implementing this particular assessment tool, we had no
12 idea how many youth had gambling problems. We have a
13 significant problem with gambling amongst our youth in King
14 County, and now our providers have implemented gambling
15 addiction programs for adolescents as a result of that
16 knowledge.

17 We did not know. We knew that our youth were
18 being victimized. We didn't know the extent of it. We now
19 know that 35 percent of our youth going home each night
20 have a fear of being victimized that very night. That
21 certainly impacts the programs that we implement. We have
22 significantly increased our treatment retention and
23 completion rates over the last several years. The State of
24 Washington has a fairly sophisticated mechanism for
25 monitoring treatment completion and retention, and King

1 County for adolescents has the highest retention and
2 completion rate in the State of Washington. 74.9 percent
3 of our youth are still engaged actively in treatment 90
4 days post-admission, so we're very excited.

5 I do need to knowledge that I have several
6 colleagues back home who couldn't be here today who were
7 instrumental, primarily our provider community. I have a
8 provider community that is incredibly engaged in this
9 process. We put a framework around it because when I say
10 incredibly engaged, it doesn't mean they weren't resistant
11 and they weren't frustrated and there weren't a lot of
12 challenges, but we've worked through those. Every time I
13 found a provider who was frustrated, I had to stop and ask
14 myself maybe I'm not providing the vision. If I found a
15 provider that was having challenges with any aspect of
16 this, I stopped and tried to figure out what it was we were
17 not providing. So we provided a vision. We provided a
18 plan. We provided incentive. We provided what it took.

19 I got the King County council to authorize the
20 funding for a two-year period for what we called our
21 science to service coordinator. So I had a science to
22 service coordinator who reported directly to me who I could
23 deploy to our providers when they were having challenges
24 implementing these various best practices.

25 So that's our short story, and thank you very

1 much. I'm honored to be here and honored to take this back
2 to Seattle.

3 (Applause.)

4 DR. CLINE: Kathleen?

5 MS. SULLIVAN: Is there anything off the table
6 that you can tell us anecdotally why you have the 70
7 percent, something that's just out of the exact modalities?

8 MR. VOLLENDROFF: I believe that we have the
9 highest retention rate because we now have better
10 assessment tools to adequately place the youth in the
11 appropriate level of care from the very beginning. I have
12 a provider network that, again, is 17 providers who have
13 the ability to refer into residential care, into detox
14 services. I do have to acknowledge Ken Stark, who is
15 sitting here at the table, who is our former director in
16 the State of Washington in drug and alcohol. The State of
17 Washington is very progressive around its continuum of
18 services. So consequently now we have a better opportunity
19 to identify the particular level of care and then place
20 them. I believe that has led to better outcomes.

21 DR. CLINE: Ken?

22 MR. STARK: The thing Jim isn't saying that I
23 have to say is that prior to Jim taking the job at King
24 County, the success stories -- and this is but one that he
25 could tell -- weren't as strong. King County is the

1 largest county in Washington State, and generally speaking
2 the largest counties are the most difficult to manage
3 because people tend to be more into power and control than
4 coordination and collaboration. Jim has done a stellar job
5 at bringing the community together and focusing on quality,
6 not just quantity.

7 DR. HENNESSY: Next we'll hear from Dr. Brian
8 Hepburn, Maryland.

9 DR. HEPBURN: Thank you. First of all, let me
10 thank all of you, specifically Kathryn for the help she's
11 given us over the years, and also Terry. We value the
12 partnerships that we have. This award that we received is
13 really part of our efforts towards transformation. We see
14 this as the direction that we need to be going.

15 Also, let me thank you for the award. Usually
16 in this business, we catch all the negatives. If there's
17 something in the paper, it's because something has gone
18 wrong. It really is nice to get an award.

19 (Laughter.)

20 DR. HEPBURN: With that, I'd like to show my
21 appreciation for a couple of people that are in the
22 audience. Steve Reeder and Christine Johnson, if they
23 would stand up, these are the two people that are really
24 most responsible for us being able to move in the direction
25 that we've gone. They have beat the leadership over the

1 head repeatedly in the Department of Education and in our
2 department to make sure that supported employment was
3 recognized as being very important, and I think it takes
4 people like them in order to keep the agenda visible to the
5 people that are making the policy decisions. They beat on
6 us, we beat on our secretary. Our secretary is John
7 Colmers, who I know Terry knows very well, and he is very
8 supportive of mental health. We have a governor who is
9 very supportive of mental health, Governor O'Malley. But
10 without people like them beating on us, we'd move on to
11 other agendas. Whatever is the agenda for the day,
12 whatever is the newspaper article for the day, that's what
13 would catch our attention. So I want to thank all of you,
14 and I also want to thank them.

15 We're very fortunate in Maryland. Aside from
16 the fact that it takes two hours to get a mile, I'm glad
17 that that's not my administration's responsibility. I came
18 from Columbia this morning. It took me two hours. I
19 couldn't believe it. You people should be getting an
20 award.

21 (Laughter.)

22 DR. HEPBURN: We started our new public mental
23 health system in 1997, and at that time what we wanted to
24 do was to move towards a fee for service system where it
25 was invisible as to whether you had insurance, whether you

1 had Medicaid, or whether you were uninsured. Consequently,
2 we basically have the same services and we pay the same for
3 individuals who are uninsured as we pay for Medicaid. Part
4 of this is because of the realization that people go on and
5 off Medicaid, and we wanted to make sure people continued
6 to get services.

7 So the first few years what we were really
8 focused on was individuals getting services and being able
9 to pay providers. We were just in survival mode. After a
10 few years we were successful at that, then we started
11 looking at maybe we should figure out if these services are
12 being helpful to anybody. Maybe we should make sure that
13 they're quality services. So we moved into a partnership
14 with SAMHSA, with our academic partner, which is the
15 University of Maryland, also with Dartmouth, with our
16 private partner, which was Johnson and Johnson, and we
17 tried to move towards evidence-based practices.

18 We have truly embraced the goal of reaching
19 evidence-based practices, and we've developed an
20 evidence-based practice center at the University of
21 Maryland that we believe is working very well. Initially,
22 supported employment was one of our targeted evidence-based
23 practice programs, and we started with some pilot programs.
24 We felt confident as of last year that we had learned the
25 lessons that were necessary to take it statewide. So we

1 basically made the leap from being a grant-based program to
2 being a program partly fee for service where the
3 expectation is that providers move to the evidence-based
4 practice.

5 We now have 30 providers that are within our
6 evidence-based practice network. That's two-thirds of our
7 providers that are doing evidence-based practice supported
8 employment. We're very proud of that. I believe we're
9 number one in the country in terms of the number of
10 consumers that are in evidence-based practice supported
11 employment programs. So we take a great deal of pride in
12 that.

13 But the thing I want to emphasize is that
14 Maryland would not have done that if it was just up to
15 Maryland alone. We really see this as part of the
16 collaboration with our federal partners, with our
17 university partners, and with our private partners like
18 Johnson and Johnson. Beyond that, what has happened is
19 that consumers have embraced this, providers have embraced
20 this. It really has been a collaboration of all
21 stakeholders from the beginning, and that's what I think
22 has made it successful. Thank you.

23 (Applause.)

24 MS. HUFF: I just have to say, Dr. Hepburn,
25 that this award should really be extended into your world

1 of children and families in your department as well. June
2 Walker and Al Zachik have really epitomized in this country
3 a real true partnership between a family organization and a
4 state department of mental health. So I want to thank you
5 for your efforts in that.

6 DR. HEPBURN: Can we get another award?

7 (Laughter.)

8 MS. HUFF: I would extend that award into that
9 also. I just had to say that. Thank you.

10 DR. HEPBURN: Thank you. We're really blessed
11 in Maryland because Al Zachik is a terrific representative
12 of the Mental Hygiene Administration, and he's another
13 person that carries a heavy stick when he comes into
14 meetings. It's all kids, kids, kids. Sometimes you get
15 sick and tired of hearing about kids, but every meeting
16 it's what about kids?

17 DR. HENNESSY: Thanks, Brian.

18 Our next presenter is Margie MacLeod from
19 Portland, Oregon.

20 MS. MacLEOD: I, too, just want to let everyone
21 know how very pleased I am to be here today, and I really
22 want to thank SAMHSA for the Science to Service Award that
23 my agency is very thrilled to have received. We were
24 really very happy with the results of our evidence-based
25 practice implementation, The Incredible Years, just due to

1 the really positive response we've gotten from parents and
2 children. To receive this award for our efforts just feels
3 like a very, very big honor to us.

4 I am here by myself today from Portland, Oregon
5 but really am representing a really large group of
6 therapists, mental health professionals who delivered
7 parent group services and children's social skills groups.

8 We partnered in order to bring the services to the
9 community with child care centers. So I'm representing a
10 lot of preschool teachers and center directors and
11 childcare staff as well who have participated in our
12 program by providing us lots and lots of space to provide
13 groups in and a lot of collaboration and efforts to get
14 families involved. So I wanted to mention them to you as
15 well.

16 Morrison Child and Family Services is a large
17 non-profit social service and mental health agency in
18 Portland. The delivery of public sector mental health
19 services has been really critical to our agency and
20 important to us for a very long time. We were founded in
21 1947, about 60 years ago, by Carl V. Morrison, who was one
22 of Oregon's first child psychiatrists, and today we operate
23 a full range of services, 25 programs in 18 different
24 locations throughout the Portland metropolitan area and
25 directing all of these services to kids and families.

1 Morrison is the largest provider of outpatient
2 services in the State of Oregon and a leader really in the
3 development of early childhood mental health services,
4 which is actually what brought us to The Incredible Years,
5 which is the evidence-based practice implementation. I
6 think it was around 2000 we really became interested in
7 responding to what we saw as the pressing social and
8 emotional needs of young children in child care settings,
9 particularly community child care centers and family home
10 providers, and we developed an early childhood mental
11 health consultation program. The Incredible Years was
12 introduced into our early childhood consultation program in
13 2002 with SAMHSA funding, I might add. We were one of the
14 early Targeted Capacity Expansion Grant programs.

15 So our program in the early design of it was
16 really to combine these early childhood consultation
17 services, which is a promising practice and very known and
18 familiar in our early childhood system, with kind of a gold
19 standard evidence-based practice program, The Incredible
20 Years, which was more unfamiliar and unknown. So our idea
21 was to piggyback a more unfamiliar program onto a well
22 established program, which I think was actually a key to
23 success for us.

24 So The Incredible Years, for those of you who
25 are not familiar with it, is a parent and child group

1 program developed by Dr. Carolyn Webster-Stratton in
2 Seattle, Washington. She developed and researched the
3 model in Head Start centers in Seattle. The Incredible
4 Years is actually both a prevention program and an
5 intervention strategy. It can be implemented in either
6 way, and it is a program that's aimed at reducing early
7 aggressive behaviors in preschool children so that
8 subsequent more serious aggressive and delinquent behaviors
9 do not occur in adolescence or later in adulthood.

10 So our implementation actually spanned the
11 years 2000 through 2007. We started our first parent
12 groups in 2003; 2004 brought the expansion of our
13 SAMHSA-funded program to nine new child care centers,
14 several Head Start systems, and over 60 family home
15 providers. In 2005, we began the children's group
16 component of The Incredible Years, and also brought the
17 services to an adjacent county, Washington County in
18 Oregon. Finally, in 2006 and 2007 we've really kind of
19 gone back and implemented the services with diagnosed
20 children in mental health clinics, and Morrison Child and
21 Family Services sites have been where we've implemented our
22 outpatient services.

23 It is really actually with a lot of pride that
24 I show you this slides that shows that we have implemented
25 99 parent and children's groups over the last three or four

1 years. Actually, upon receiving this award, my CEO said we
2 really need to celebrate our 100th group in a special way,
3 so I think we're going to do that. Thirteen of the groups
4 were provided in Spanish with bilingual staff. So that's a
5 pretty big effort in that area as well.

6 Six of our staff received certification as
7 parent group leaders by Carolyn Webster-Stratton's shop in
8 Seattle to have received it in the delivery of children's
9 groups, and then one person has received certification as a
10 mentor trainer. She is actually one of four people in the
11 United States who has achieved this certification from the
12 Seattle-based organization. The certification allows us to
13 train ourselves at Morrison. We can now train our own
14 staff and our community partners, and it gives us a high
15 level of clinical expertise about The Incredible Years
16 inside of our program and organization and saves us some
17 dollars in training costs as well. So we're actually very,
18 very proud of that accomplishment.

19 As I think about our evidence-based practice
20 implementation, I think that we were successful because we
21 had this foundation of collaborations and partnerships in
22 the Portland early childhood system. We actually started
23 small, and then it grew, and for me I think starting small
24 was a key to success. We shifted from a kind of treatment
25 perspective to a promotion and prevention perspective very

1 early on and identified that that was a need that we had.
2 Our implementation I think really actually required us to
3 work with our mental health staff in a very different way
4 than what we had before and to kind of take that on as
5 workforce development. We learned that mental health
6 professionals didn't really bring to their work some of the
7 skills that they needed for prevention services, primarily
8 outreach skills, health promotion, giving presentations and
9 training, marketing, and so we built training programs and
10 clinical supervision around these skills.

11 We also discovered that the evidence-based
12 practice program, The Incredible Years, required high
13 levels of group facilitation skills. So we did training
14 and support in that area. Carolyn Webster-Stratton was a
15 tremendous support to us. We used her wisdom and
16 consultation, and she was full of thousands of ideas. I
17 think we adopted her metaphor for collaboration, that we
18 were building a house together, that Carolyn was the
19 architect and we were the builders.

20 I think another thing that we did that was very
21 successful was that we paid a lot of attention to fidelity
22 early on and figured out ways to put fidelity into daily
23 practice. The clinical supervisor of the project and I met
24 and decided early that we really were going to resist the
25 temptation to adapt and change the model while we were

1 learning it, that we just simply wanted to learn it and do
2 it, and I think that was also very helpful to us.

3 We learned new ways to engage parents and to
4 engage child care workers, and I think that was based on a
5 strength-based philosophy and outreach and marketing and
6 using parents to present the services. We just listened to
7 parents.

8 I wanted to end -- I guess that's the bell --
9 with some quotes from parents about their experiences in
10 our services. I particularly like the second one which a
11 parent just said that their experience in our group changed
12 their lives and their family life in a big way. Another
13 mom said that she really learned how to play with her child
14 and she learned about herself. We had enormous positive
15 response from our parents. That was very inspirational to
16 everyone.

17 (Applause.)

18 MS. POWER: Can I ask what the Dinosaur School
19 is?

20 MS. MacLEOD: What is it?

21 MS. POWER: You had that listed as one of the
22 trainings.

23 MS. MacLEOD: Yes.

24 MS. POWER: What is that?

25 MS. MacLEOD: That is the children's social

1 skills group, which is actually another whole story that's
2 really fun. It's a puppet program. Wally and Molly come
3 to groups to teach children social skills, friendship
4 skills, problem solving, learning about their feelings,
5 learning about the feelings of others, which I think is
6 actually kind of unique to the Dinosaur School. The
7 puppets are life-size if you're a preschooler, and the kids
8 are just totally enthralled with the puppets and receiving
9 information through the puppets and the role-playing that
10 you can do with puppets. The kids really love that. The
11 puppets also entice parents to come to their parent groups
12 and to get their children involved.

13 DR. HENNESSY: Next we'll hear from Virginia
14 Hoft at Santa Fe Adolescent Services in Fort Worth, Texas.

15 MS. HOFT: Hi. Thank you so much for having us
16 here and recognizing the work that we do, as well as the
17 families and kids that we serve. We're in Fort Worth,
18 Texas, and we serve all of Tarrant County, which includes
19 Fort Worth and a lot of smaller municipalities.

20 Santa Fe Adolescent Services has been around
21 since about 1996, and we're the only Medicaid provider for
22 adolescent day treatment for it's felt like 492 years. I
23 don't think it was quite that long, but it was a long time.

24 You have to have a perspective of where we've
25 come from. In about 2000 we had a folder that we put

1 certain pieces of mail in that had the initials on it "if
2 we're here next month." So there was me and the lady who
3 ran the office part time and a dead dog in the parking lot
4 and a couple of folks working with the kids, and we went to
5 town.

6 So to be here now and be recognized by you
7 guys, as well as kind of demonstrating some of the
8 milestones we've hit and some of the incredible work that
9 we do, it feels really, really good that those blood, sweat
10 and tears have paid off. I have an incredible staff and
11 I'm going to introduce them in a minute.

12 Santa Fe Adolescent Services' mission is to
13 provide accessible and innovative prevention, intervention
14 and counseling services to youth and families most in need,
15 and that sounds just like your run of the mill mission
16 statement, but there's a lot of heart and soul in that with
17 the words "accessible," "innovative" and "most in need."
18 Santa Fe made its footprints, if you will, with doing
19 Medicaid day treatment. That was before Medicaid was
20 rolled out by managed care. It was prior to those days,
21 and we saw the kids that literally fell through the cracks
22 and weren't going to school and nobody really noticed, and
23 we became a very, very community-based neighborhood kind of
24 drug treatment center where we saw mama and we saw the
25 neighbor, and she'd drag the neighbor's kid over there

1 because he's getting high too. So it was very much a
2 grassroots agency, and what we learned from that is that
3 "accessible," "innovative" and "most in need" are very,
4 very key words.

5 Our core values reiterate that, that we believe
6 that all youth deserve access, and what we saw a lot of is
7 that it wasn't all kids. It was a lot of kids, but it
8 wasn't all the kids, and that a lot of times what we saw
9 with our kids is that they kind of got what was left over.
10 They didn't get the innovative and the critical. They got
11 the leftovers. What we were committed to is that they need
12 more than anybody, they need innovative. The
13 community-based programs is when families are in crisis and
14 when families are struggling financially, to set up shop
15 and to expect them to come to us was a little ridiculous.
16 So we realized that in order to truly be community-based,
17 you have to be part of that community, aware of that
18 community, and sensitive to that community.

19 With this, what you see here is all of the
20 different programs that we do now, and everything in yellow
21 are all evidence-based programs. I would love to tell you
22 this really altruistic kind of thing that we got into
23 evidence-based programs because we knew it was just the
24 thing to do. That's not true. When we did treatment,
25 there wasn't anything, and we had people putting together

1 manuals or walking into group with what am I going to do
2 now, and then when we started kind of getting into
3 prevention, you could go to this website, and this was five
4 years ago. You could go to this website and they had these
5 programs and they were in a box and they were easy to
6 follow and they had all the goals written down and you
7 could write a grant really easy, and this was awesome.

8 So we kind of started with that with one grant,
9 and then we just realized that there was something to this,
10 there was really something to this and that when you hire
11 someone who will work for what we pay, they're generally
12 out of school and they think they know everything, but they
13 don't, and they needed some guidance. What we could do is
14 we could take someone who was just out of school who had a
15 little bit of information and we could give them a
16 foundation to build from, and then they could kind of
17 create from a benchmark instead of walking in with the
18 "what am I going to do today."

19 So these are all the different things that we
20 do, and we just found out yesterday that we were awarded by
21 SAMHSA the Brief Strategic Family Therapy Program that
22 we're going to be implementing with juveniles that are in
23 court adjudication. That's not on here, but we're really
24 excited about that. These are the ones that we're actually
25 going to talk about now.

1 All of our programs are either school-based,
2 community-based or home-based, and then we have some
3 juvenile services contracts that, just like the kids, we go
4 where they tell us to go. So those happen to be in our
5 offices, but everything, unless there's somebody making
6 them go somewhere, they're all in the school or in the
7 community. Second Step, Reconnecting Youth, and
8 Strengthening Families is what I'm going to talk about.

9 Reconnecting Youth is a SAMHSA model program.
10 It's for 9th through 12th graders. They meet daily and
11 they get school credit for this, which is really awesome.
12 You go back to that accessibility piece and innovative.
13 Kids are going to be at school. That's where they're going
14 to be, so you might as well put your services right there
15 with them, and you give them credit for it, and it's just a
16 win/win. This has been a really successful program for us.
17 It's designed to increase school achievement, decrease
18 drug use and increase mood management.

19 We started out doing this in 2001 through a
20 grant through DSHS, which was (inaudible) then. We served
21 315 kids, and they were all attending the juvenile justice
22 alternative education program. I'm going to kind of tell
23 you that I know it's not about numbers, but there is
24 something to be said I think for us, the fact that we had
25 one person at the front desk, one counselor and a dead dog,

1 that we started from that and that we've come to where we
2 are. If we weren't doing something right and if they
3 weren't quality services, we wouldn't have made it to this
4 table.

5 So in 2006, this last school year, for this
6 Reconnecting Youth program, we served 485 students. We are
7 now in six schools, four different school districts, and we
8 have just been added to Fort Worth ISD's Bulletin 100. I
9 don't know if that means anything to you all. This was a
10 lot of effort and energy and a lot of showing up, like we
11 said we'd show up, but now we have a course number.
12 Reconnecting Youth has a course number for Forth Worth ISD,
13 and any principal that wants it in their school, they can
14 request us because we've done everything that we need to
15 do, and we can go into the Fort Worth schools, because Fort
16 Worth is a little trickier than some of the other little
17 schools where they just kind of let us in and let us do it.

18 Now, we don't have enough facilitators to do
19 this, but we're kind of hoping it will be like the fishes
20 and the wine when Jesus did his little thing on the beach
21 when there weren't enough fish and there wasn't enough
22 wine, but all of a sudden there was enough. So we're just
23 going to do what we need to do and hope that facilitators
24 and money come along.

25 The evaluation results is that 75 percent of

1 those students have shown an increase in their GPA. One of
2 the challenges I think that we see a lot with
3 evidence-based programs is DSHS is our funder, and they
4 decide what it is that we need to measure. One of the
5 challenges is that Reconnecting Youth and increase in GPA
6 is really not a telltale measure, but that's the measure
7 and that's what we measure because that's what we're told
8 to measure. We don't have money to measure a lot of other
9 things. So that's about that.

10 Second Step Violence Prevention Program is
11 another SAMHSA model program. It meets once a week. It's
12 for middle-schoolers and it deals with empathy, problem
13 solving, impulse control, and anger management. This
14 program in 2001, we provided this little program for 150
15 students annually, and in 2004 that jumped up to 4,200
16 kids. Now we serve about 5,000 kids annually. We're in 28
17 schools and five different school districts. The way it
18 stands now, this coming year every middle school kid in
19 Fort Worth ISD will have received the Second Step
20 Prevention Program. So we're working real closely with the
21 district, and they see what's happening, and they're
22 working with us to be sure that it's consistent across the
23 board, as well as in outlying areas.

24 This is another really tricky one for
25 evaluation. DSHS has this tool that we're working with,

1 and we're having a lot of trouble with that tool. But even
2 with the trouble with that tool, it's 65 percent
3 demonstrate an increase with social relationships and
4 problem-solving skills.

5 The next one is Strengthening Families. This
6 is the baby. This is just an awesome program. It's a
7 SAMHSA model program.

8 It's an eight-week program for youth ages 10 to
9 14 and their families. Parents and youth meet separately
10 for an hour and then they join together for the second
11 hour. All of these groups are held in the community with a
12 community partner -- schools, community centers, churches.

13 The thing that the developers mention that I think is real
14 important is they mention these things. We put this in the
15 grant, and what we do is we look at every obstacle that
16 will keep that family from coming to us. We provide
17 dinner, we take a crock-pot dinner, we provide child care
18 on site, we provide transportation, we work with the food
19 bank to provide each family a bag of groceries to take
20 home, and all of our groups are bilingual. I forgot to put
21 that up there. All of our groups are bilingual, and we
22 found pockets of non-English-speaking large groups that
23 just amazed us. We didn't know that those communities had
24 lots of non-English-speaking families.

25 This program -- in 2001 I wrote a grant and

1 thought how in the world are we going to get 98 families.
2 By 2004 and currently we serve 576 families. We have more
3 than 20 community sites, planned a year in advance. We
4 have sites now on our waiting list to get into our rotation
5 that we can't even get to all the sites that we need to get
6 to.

7 The evaluation results. I put 95. We show 98
8 percent, but I think I believe that. Ninety-eight percent
9 of the families truly complete this program, and there is
10 100 percent of the tool that we use that's issued by DSHS
11 shows that there's definitely increase in family
12 problem-solving skills.

13 Other things here is that if they miss a group,
14 my staff, who are just incredible, go out to those families
15 and deliver them that missed lesson so that they're not
16 behind. The thing here about this is that it's not just
17 about the curriculum. It's about knowing what the families
18 need and going over and beyond and connecting them with
19 other services, not just what's in the curriculum. A lot
20 of people, their problem is that they'll say this
21 curriculum, the manualized perspective doesn't meet the
22 needs of my client. Well, I think that I'm a major fan of
23 evidence-based manualized programs, and I think that those
24 are the easiest things to overcome.

25 I think critical to success is a quality

1 assurance plan, which includes fidelity, mentoring and
2 training. When I talk about fidelity, what I'm talking
3 about is that fidelity to everything the curriculum
4 suggests, not just the curriculum. It's the
5 transportation, the food.

6 If you look here, what I did is what is
7 incredibly important for our agency is this training,
8 mentoring, supervision piece. If you see that gray line
9 there that says "coordinators," I think I tried to do
10 something special with this. I don't know if it's going to
11 do it. No, it's not going to do it. My coordinators are
12 here, and they're incredible, and I'm going to introduce
13 them now. They're probably going to be embarrassed. It's
14 Cora Mosley, Estrella Griggs, and Vanessa Quach, and they
15 are incredible.

16 (Applause.)

17 MS. HOFT: What we have under them are team
18 leaders, and the reason that that is important is that
19 those team leaders are mentors. They are not supervisors.
20 They are mentors in the curriculum to be sure that those
21 team leaders understand how the curriculum needs to be
22 implemented. Coordinators, team leaders and all the
23 facilitators are all trained in the curriculum. So it
24 includes mentoring and shadowing and supervision. We have
25 a very detailed quality management plan that we follow,

1 very strategic and stringent to be sure that we follow
2 fidelity.

3 I think also critical to success is community
4 partners, community-based programming, and I think this
5 kind of says it all for us. We treat our participants like
6 they're family, and we treat our community partners like
7 they're our customers. I think as a result of that, we now
8 have more than quadrupled our budget since those days we
9 had a file where we thought if we're still open. So I
10 really appreciate you recognizing us and giving us this
11 opportunity to brag.

12 (Applause.)

13 DR. CLINE: Barbara?

14 MS. HUFF: I'm sorry, but we have never
15 followed directions on this council. So the fact that I am
16 not holding my questions is nothing new. Remember, it's my
17 last day.

18 I just want to acknowledge your enthusiasm. I
19 just love it.

20 MS. HOFT: Thank you.

21 MS. HUFF: I mean, to see someone who is so
22 excited about what they do, it's just marvelous. Your work
23 is just fabulous, and I love Strengthening Families. I
24 just love that program. It is so wonderful.

25 MS. HOFT: Yes, isn't it awesome?

1 MS. HUFF: But I just have to ask you this.
2 Are you aligned with all with the System of Care grant that
3 is in Fort Worth? Do you even know there is one there?

4 MS. HOFT: Yes. You mean through the Mental
5 Health Connection?

6 MS. HUFF: Yes. I don't know if it's the
7 Mental Health Connection, but it's through mental health,
8 your department of mental health.

9 MS. HOFT: Community of Care, Community
10 Solutions.

11 MS. HUFF: Yes.

12 MS. HOFT: Yes. We're a Community Solutions
13 partner.

14 MS. HUFF: Okay, I'm glad to hear that. I just
15 thought if you want, I was going to figure out a way for
16 that to happen.

17 MS. HOFT: Oh. Well, there's a few other
18 things that we need if you want to help.

19 (Laughter.)

20 DR. HENNESSY: Sounds like you two should talk
21 after the meeting.

22 Our final presenter is Dr. Timothy Devitt from
23 Thresholds in Chicago, Illinois.

24 DR. DEVITT: Thank you. We're really thrilled
25 to be here today. Myself and Melanie Kinley came in from

1 Chicago. We accept this award on behalf of the consumers
2 and staff at Thresholds. We're excited and proud to have
3 the award, and at the same time we also know that we're not
4 done yet, that we have quite a bit of work to do. These
5 models continue to evolve, and with that we're going to
6 continue to hopefully be able to provide better services to
7 folks who have co-occurring disorders.

8 That's what we're receiving the award for, and
9 the model we've been using over the last few years to try
10 and deliver these services is the Integrated Dual Disorders
11 Treatment Model, which is endorsed by SAMHSA. What I want
12 to do today is just kind of share our journey over the last
13 17 or 18 years as we began to deliver services to folks
14 that have co-occurring disorders and how things really
15 started to take shape for us a few years ago with the
16 introduction of IDDT, or Integrated Dual Disorders
17 Treatment.

18 A little bit about Thresholds. Our doors
19 opened in 1959. We were a very small storefront mental
20 health program on Dearborn Avenue in Chicago and primarily
21 served people who were discharging from the state
22 psychiatric institutions. Today we have 35 programs and
23 over 75 residential sites representing four counties in the
24 Chicago area, 850 staff, and our program budget and
25 membership continue to grow. We also have very specialized

1 services, serving people who are homeless, young adults, we
2 have specialized programs for deaf people who have
3 psychiatric disabilities, mothers with children programs,
4 jail diversion programs. The residential Centers for
5 Recovery are clubhouse-type programs, and lots of outreach
6 programs, ACT-type programs, again primarily serving those
7 people with severe and persistent mental illness.

8 We revised our mission statement about three
9 years ago, and I share it today because it hopefully shows
10 some of our interest in recovery and in trying to implement
11 EBPs and how the EBP implementation really helps us steer
12 recovery, focus service delivery, and working to help our
13 folks reclaim their lives by providing the support, skills
14 and respectful encouragement they need to achieve hopeful
15 and successful futures.

16 We're mostly sharing our goals. You can see
17 those there. Just help people have homes, good jobs,
18 education, good friends and loving families, health,
19 optimal health, opportunities for that, and staying out of
20 crisis.

21 In 1989, we began to realize that a number of
22 the people we were serving were having consistent
23 psychiatric hospitalizations and periods of homelessness,
24 and when we stopped to try to figure out why, we realized
25 that a number of those people also had co-occurring

1 substance use disorders. At that time we convened a task
2 force to take a look at what was out there at the time,
3 what were the things that we could do to try to help these
4 people more. Some of the things that came out of that 1990
5 report are still relevant today, this idea that recovery
6 occurs in stages based on the stages of change model of
7 treatment, that recovery isn't linear, that it is going to
8 occur slowly over time for many people, and that we needed
9 to do more to help those people in the earlier stages of
10 treatment, earlier stages of treatment meaning people who
11 were still actively using, who hadn't yet decided that they
12 wanted to stop, who hadn't even identified that as a goal
13 yet. But what could we do to engage them in a
14 relationship, engage them in our services, maybe not making
15 abstinence the goal with them, but just to try to help them
16 with a relationship and offering practical assistance?

17 Through the early '90s and mid-90s we started
18 to offer dual disorders groups in our clubhouses and
19 Centers for Recovery. We launched three group homes that
20 focused primarily for folks with dual disorders, and we
21 also recognized the need for helping people get trained,
22 because we were primarily a mental health organization, to
23 help people get trained in addictions. We teamed up with a
24 community college and over the next 10 years over 200
25 people were able to sit for the exam to become certified

1 alcohol and drug counselors in addition to being mental
2 health practitioners.

3 In the late '90s we opened up two large
4 apartment buildings that were only for people who had a
5 dual disorder. One was on the city's south side and one
6 was on the city's north side. Also at the time, we formed
7 a steering committee, which proved to be a real important
8 piece to trying to implement services systemwide. I'm
9 going to talk about that a little bit more in a moment.

10 Then from 1999 to 2003, we started a
11 relationship with the Dartmouth Psychiatric Research Center
12 and began to learn more about assessment, stage-based
13 motivational interventions, and program evaluation. With
14 that, we were able to do more monitoring of our assessment
15 tools. We were using the assessment tools, and we were
16 able to use that data over time to kind of focus on what we
17 were doing and how we could do things better. The toolkits
18 hadn't yet come out, but at the same time we were able to
19 pay attention to our own program outcomes based on the
20 measures that we were using.

21 Although laudable, the work that we did during
22 that time, looking back, because we didn't yet have the
23 infrastructure to support what we were doing, we were doing
24 it in different areas, and the people in the programs who
25 were interested in it, we were starting with them. But

1 systemwide, it hadn't yet occurred, and what we realized
2 looking back is that what we were doing didn't necessarily
3 translate into a spirit, and we didn't always have a grasp
4 of stages of intervention. We understood that we needed to
5 do engagement, and we did, but maybe we didn't always offer
6 all the services like housing, opportunities for work to
7 people who were still using. We had these great apartment
8 buildings, but we also had zero tolerance for substance
9 use. You could use off site, but if you used onsite you
10 couldn't stay. The same with working. People were offered
11 opportunities for work, but if they were actively using,
12 that wasn't something that -- we were going to work with
13 those who were not using.

14 In that sense, harm reduction hadn't cascaded
15 yet throughout the organization. With this effort to
16 dedicate leadership to steering this process, we learned a
17 lot. A person was hired in 1999 to oversee the
18 implementation effort, and that involved bringing together
19 some other departments at the organization, including the
20 quality assurance, the training, the research people,
21 program staff, people who were really excited and
22 enthusiastic about this, and also consumers, people in
23 recovery, to kind of come together and kind of take a look
24 at what we were doing and how we could do a better job at
25 trying to make our services accessible to everyone.

1 In addition, we started to focus on skill
2 building with the staff. In addition to the addictions
3 training, we were also focusing more on motivational
4 interviewing and stage-wise assessment.

5 So with that, in 2003 the toolkits were coming
6 out. We started to pay attention to the toolkits. We also
7 had a program that was funded to implement IDDT on an ACT
8 team, and with that there was a requirement to do the
9 fidelity assessment. So that was our introduction to doing
10 the fidelity assessments, and from there we targeted other
11 programs that we wanted to start doing these assessments
12 with and identified specific goals based on the outcomes of
13 those assessments, site-specific goals. In addition, we
14 began to realize through a lot of the implementation
15 literature that was coming out at the time that our
16 classroom-style trainings really weren't helping people
17 learn the skills that they needed to learn. It helped them
18 to know about the skills, but it didn't necessarily teach
19 them how to do the work.

20 So what we started to do is offer on-site
21 training and consultation at a team level where the staff
22 would actually work with a person who could help model some
23 of this, go out with them, talk to them about it. Then
24 also pivotal was the need for the clinical supervisors, the
25 team leaders to be present, to be actively part of this

1 training, and to be able to reinforce it on a day to day
2 basis.

3 So we did that with a number of sites. I'm
4 sorry if this doesn't come out too clearly, but the idea
5 here is that using a substance abuse treatment scale, which
6 came out in '95, we were able to stage people based on
7 their stage of treatment. I'll just share that it involves
8 looking at the extent to which somebody is either
9 continuing to use or identifying abstinence as a goal or
10 not using anymore. So it's on that continuum, people
11 using, people working to stop, people have stopped, and
12 then people have been stopped for a period of time. So 1
13 is people actively using and don't have aren't quite at a
14 point where they even see a problem, to number 8 where
15 people have been clean and sober for a year or more.

16 So you can see that throughout our programs
17 most of the people were in the persuasion stage or a 3 to 4
18 rating, meaning that they were still using but perhaps
19 giving some thought to making a change. That's when people
20 are in intake, and then over a baseline and over the course
21 of their time in the program, depending on the program, the
22 residential programs, people got to a point where they were
23 actually not using, on average, and people in the outreach
24 teams and the Centers for Recovery did make some movement
25 from persuasion to late persuasion. Most of the folks were

1 homeless when we first started working with them, and you
2 can see the breakdown in terms of where they were housed
3 over time. A number of them were in their own Thresholds
4 housing, a number were in their own apartments, independent
5 leases, supported housing programs, supervised facilities,
6 and then a smaller number were in treatment facilities or
7 hospitals or in and out of incarceration.

8 This one got a little jumbled on the slide. I
9 apologize. But employment, basically most of the people
10 were not employed, about 4 percent, and then over time up
11 to 22 to 27 percent of the people were able to secure
12 employment. Again, implementing IDDT has really helped us
13 to focus more on recovery and make changes where we were
14 falling short.

15 One of the areas that I think it's helped us in
16 is it's helped us to better understand the other
17 evidence-based practices that relate to this population,
18 and we're doing supported employment now. We've been doing
19 ACT for a number of years, and we're also doing wellness
20 management and recovery.

21 Some other things that I think implementing
22 these models has helped us do is to just better understand
23 how can we do things better. One example is the large
24 apartment buildings. We have rescinded the zero tolerance
25 policies. People who do use on site continue to stay

1 there. A lot of program enhancements were made to try to
2 help people, with peer support and staff support, to kind
3 of learn from those experiences, versus asking people to
4 move. In addition, our outreach teams are continuing to
5 increase their ability to work with people who are actively
6 using and connecting them with things like jobs and nicer
7 apartments, the idea being there that a more rewarding life
8 is going to come before abstinence. So opportunities for
9 work, housing, better relationships is going to strengthen
10 one's recovery and help reduce use over time, as opposed to
11 saying you have to be clean and sober first before we're
12 going to provide these things to you.

13 Some of the lessons that I think we definitely
14 have learned is that implementing practices like IDDT does
15 take time. It's not something that is going to happen
16 quickly, and it takes dedicated time and resources as well.

17 In our case, it definitely took active leadership and
18 dedicating active leadership to help with this.
19 Supervision is essential. Helping the staff to learn these
20 skills happens on a team level, with the supervisor
21 actively involved. It's not going to happen necessarily
22 through a lot of classroom training. It could for some, I
23 suppose, but we're finding that it definitely helps to have
24 onsite TA, technical assistance.

25 Training, research, and quality improvement

1 initiatives are important, but what we found to be so
2 important is just executive-level buy-in, having our CEO
3 and associate directors behind this initiative and helping
4 the programs to implement the practices.

5 We've also found to be very helpful and
6 critical, really, is using the toolkit, using the fidelity
7 assessments, the IDDT fidelity assessments in the GOI, the
8 general organizational index, to measure how we're doing,
9 and to use those tools to provide feedback to the programs
10 on what can be done to enhance the score, a 3 to a 4 or a 4
11 to a 5, or wherever they happen to be, to set six-month
12 goals and then revisit six months later and take it from
13 there.

14 The other things that we definitely learned is
15 the importance of including our consumers in this process,
16 eliciting their involvement, asking them to join our
17 committees, to be part of the decisions that go along with
18 the policy changes that result from implementing these
19 models.

20 Then finally, the recognition that we're not
21 done yet, that implementing these practices is evolving and
22 it's a process, and as the models evolve we're going to
23 continue to have more and more work to do. That's where we
24 are. Thanks.

25 (Applause.)

1 DR. CLINE: Kathryn?

2 MS. POWER: Kathryn Power from the Center for
3 Mental Health Services. I wanted to just offer my
4 congratulations and thanks to all of you for your work.
5 You've been toiling in the vineyards for many years, and I
6 appreciate it.

7 I think my observation and question is that
8 it's very clear that innovation is really local and needs
9 to be done at the local level, as is evidenced by the local
10 programs that you talked about, and it also takes personal
11 leadership. As a person who is really interested in how do
12 we take some of the science to service efforts and bring
13 them into the transformation world, I've noticed that 20
14 award recipients are from 13 states, and these 13 states,
15 frankly, are considered to be the forerunners in terms of
16 mental health care. Most notably, five of the states also
17 have transformation grants.

18 So I think it's really important for us to note
19 that you all are in local areas and you are in regions and
20 you are in states that are really pretty forward-thinking
21 relative to investing in and moving forward. What are you
22 all doing about helping us collectively bring this to
23 scale? How do you take your innovative idea and your
24 practice and bring it to scale in your region or in your
25 state, or how will you, Brian, take your success with

1 supported employment and do it with the other
2 evidence-based practices in the way that you've done it on
3 the state level? I mean, have you developed learning
4 communities? How are we going to bring these sort of
5 pockets of excellence to a scale and a scope that we really
6 want to have in our science to service agenda? So just
7 some thoughts about that.

8 DR. HEPBURN: What we recognized early on is
9 that we didn't have the expertise to do it on our own.
10 We're fortunate in Maryland in that we're a small state,
11 we're a wealthy state. SAMHSA is in our state. CMS is in
12 our state. That can be a positive or a negative.

13 (Laughter.)

14 DR. HEPBURN: But we are blessed with a lot of
15 resources, and that's very helpful. What we recognized,
16 though, as a state government is that we couldn't do this
17 by ourselves. So what we did is form a partnership with
18 the University of Maryland and developed an evidence-based
19 practice center. Initially it was basically for severely
20 mentally ill. However, this past year we added a child and
21 adolescent component, and let me just talk about the child
22 and adolescent component a little bit.

23 That's the result of work we started around
24 2000 where we developed a relationship with the University
25 of Maryland and Johns Hopkins with their child psychiatry

1 divisions, and we started having weekly meetings with them
2 on what we could do with interaction in both directions to
3 improve their services and improve our services, but really
4 focused on quality.

5 So the relationships that we have with the
6 universities has helped us to get the academic input. Our
7 relationship with the academic area allows them to get the
8 practical issues, what are the problems that we face on a
9 regular basis. So by combining the academic and the
10 practical, we think that we have a good formula for
11 actually being able to move ahead with quality. Last year
12 we moved ahead with a sort of community treatment, family
13 psychoeducation and supported employment to move from the
14 pilot stage to trying to take it statewide. Now we're
15 working on co-occurring. We're also looking at kids issues
16 and what we can do to move them towards evidence-based
17 practices.

18 So for us, it's having that relationship with
19 the university and trying to gain that expertise that will
20 help us to move forward.

21 The other piece, of course, is the financial.
22 You can have a really good system, and if you don't have
23 the financial incentives in place, it's not going to be
24 generalized. It's going to stay local. We've worked very
25 hard on that and we've gotten a lot of support from our

1 legislature and from our executive branch to be able to do
2 that.

3 DR. CLINE: Kathleen?

4 MS. SULLIVAN: You know, I would give my eye
5 teeth to have a morning talk show right now because I would
6 put every single one of you on for two hours to explain to
7 people out there what real systems of care are. I found it
8 extremely frustrating last night when I turned on the debut
9 of "Tyra," and all she showed was promises. What I want to
10 know is, do you all battle an expectancy of care? Because
11 the media only shows the promises or the Betty Fords. When
12 people first come into the system, what do they expect of
13 you, and do we have to better publicize real care and help
14 you at the local level with your stories? Do you know what
15 I mean? So that people don't constantly think that they
16 have to be a millionaire to get drug treatment. Is that an
17 issue for any of you with expectancies of your clients?

18 MS. MacLEOD: I'm not an alcohol and drug
19 treatment provider, and that wasn't related to our practice
20 implementation, but I resonate with something that you said
21 in that when you're out there in mental health prevention
22 and promotion, the idea is that you really are talking to
23 the community about mental health services and talking to
24 them in everyday language in terms and ideas and stories
25 that are about them and their lives and are not about the

1 kind of strange words and jargon that we put on things. In
2 our experience in going out to child care centers and
3 talking to center directors, one of the first things they
4 told us in the first week of our SAMHSA implementation was,
5 well, just come in and do whatever you want. It really
6 sounds good, but just don't call it mental health. They
7 were worried about the fear and the stigma kind of
8 associated with that, and that really challenged us to kind
9 of come up with talking in a real genuine way to people
10 about needs.

11 DR. CLINE: Jim, it looks like you have a
12 comment, and then Virginia.

13 MR. VOLLENDROFF: Yes, I just want to make a
14 quick comment. You know, one of the things that we battle
15 on a daily basis in the field of chemical dependency is
16 stigma, and one of the stigma issues that we deal with is
17 that the outpatient treatment that we provide in our
18 community is ineffective. We still battle that on a daily
19 basis. I just saw some statistics in the State of
20 Washington that said 40 percent of the youth in our
21 outpatient programs complete treatment. Well, that's as a
22 whole, but I can tell you that in King County it's 59
23 percent of our youth who complete treatment. So I think
24 that we need to battle that on a regular basis.

25 You know, I have people come to me because I'm

1 a drug and alcohol coordinator and say what's a great place
2 to send my kids? I know what they're asking me. They're
3 saying I don't think locally we have good providers, but
4 where is someplace nationally? I tell them right down the
5 street, here's my list of providers. We've got great
6 treatment at the local level, and that's what we need to
7 sell.

8 DR. CLINE: Virginia?

9 MS. HOFT: In terms of adolescents, I think
10 that the systematic thinking that is really the challenge
11 is that we do too little too late. With an adolescent, you
12 have a small window of opportunity that you've got to
13 snatch them up and get something done. I think that
14 prevention -- the system is -- well, we are. I have a
15 great county, and we do a lot of really great things, and I
16 don't think it's our county. I think it's the way we
17 think, that you give them a little when they're a little
18 trouble, and you give them a lot when they're in a lot of
19 trouble. It's that whole prevention mentality that I
20 believe that if we could have a different mindset to where
21 you give them a lot when they're getting started, because
22 the chances of truly intervening on some behavior that's
23 headed downhill when they're 16 and they're a daily cocaine
24 user, I think there's an expectation you throw them in
25 treatment and they're going to get better.

1 I think that treatment does great things, and
2 I've done treatment and prevention intervention, and I
3 think a cocaine addict that's 16 years old who never uses
4 cocaine again after getting after drug treatment is an
5 expectation that people have. But if you've worked with a
6 16-year-old cocaine drug addict, that is almost impossible
7 because he's 16, all the stuff we know about addiction.
8 But if you can catch him at 13 busting out windows and
9 breaking into cars and smoking pot, let's see if we can't
10 really get him the services there so that we don't continue
11 to set our expectations on the impossible and we continue
12 to fall short, and we continue to look unsuccessful. I
13 think a lot of it is we're just doing too little too late
14 with adolescents in particular.

15 DR. CLINE: We have about 10 more minutes
16 before we move to our public comment section. Any other
17 comments?

18 DR. DEVITT: I just wanted to add that with our
19 population, primarily people who are homeless at the front
20 door, they're outreached and engaged into the services, and
21 one of the barriers our staff experiences is just accessing
22 nice housing, decent and safe housing for people in the
23 very beginning. So I think that's just a barrier to
24 helping make other positive things happening down the road.
25 We kind of see that as a major first step.

1 DR. CLINE: Dr. Gary?

2 DR. GARY: I want to thank each of you for such
3 excellent programs, and I know it takes a lot of work and a
4 lot of thinking to be able to present for five or seven
5 minutes. Hours and hours and hours of work has gone into
6 this, for years, and I want to acknowledge that and to
7 thank you for that.

8 I think all of the programs are just very
9 excellent. Of course, there are different modalities,
10 different populations, but nevertheless a tremendous need.

11 I was wondering if I were to tell someone in my community
12 about this program, would I be able to tell the person to
13 go to the Internet and click X, Y, Z and get the program?
14 You will find a detailed explanation of your program, the
15 two kids, your evaluation data, et cetera?

16 My question is a follow-up from Ms. Powers',
17 and that is dissemination and next steps. How is it that
18 we can make what we know is excellent available to people
19 in communities so that we can enhance community-based,
20 community-driven selection of programs, and community
21 empowerment? I know that the Internet is just one way, but
22 other ways I would be interested in, but that would be a
23 first way and a very easy way to make what you are doing
24 available to other people in communities who may not have
25 all of the expertise that you have but certainly are very

1 much aware of the issues and the problems in their
2 communities and have the leadership and skills to take a
3 program that is sanctioned, if you will, where we know the
4 efficacy of those programs, and to implement it in other
5 under-served communities.

6 DR. CLINE: I also would like to put Kevin on
7 the spot with that question, because I think there are
8 implications for SAMHSA. But Ken, you have a comment
9 that's related to Dr. Gary's question?

10 MR. STARK: Unrelated to her comment.

11 DR. CLINE: Okay. So can we go and see what
12 Kevin has to say?

13 DR. HENNESSY: Well, I will address that in a
14 minute. I also wanted to make sure that I usually tend to
15 be a pretty tough guy to impress, and I just find that your
16 stories and your experiences and the continuing work that
17 you're doing I find actually truly inspirational. I think
18 that that was part of our goal at SAMHSA in beginning to
19 put this program into place, that I fully knew that there
20 were these kinds of experiences out there, but we needed to
21 do something to really showcase them at the national level
22 and hopefully give you all an opportunity to celebrate your
23 success. But I think the key is then to take a little bit
24 of time to celebrate the success but then work with us in
25 helping to really communicate to others your journeys in

1 this process.

2 I think you can look at the lessons learned,
3 and there are some major themes there that are popping out
4 that are actually very important to the work that SAMHSA is
5 doing in workforce development. You all are training
6 people in these evidence-based practices. They don't just
7 magically get put into place. There are all kinds of steps
8 that you all know because you've lived this experience. So
9 I think hopefully there will be some ongoing opportunities
10 to work with us and to work with others in your communities
11 so that we can continue to really spread the work that
12 you're doing and have it influence others in your
13 communities and others in your states and regions.

14 MS. SULLIVAN: Could I add to that? Is it
15 possible that on our website at SAMHSA that we could
16 actually put an awardee category and to tell everyone why
17 this award was given and that each one of you could be
18 responsible for putting either the slides or the
19 information so it shows why they got the award? Maybe it's
20 just doing it through a website.

21 DR. HENNESSY: Right. When we issued the press
22 release yesterday, we have a link to a new webpage which
23 has a brief description of the awards, as well as a one to
24 two paragraph summary of the organization of each of the
25 award winners, their organizations, and then a link to

1 their own webpage. Certainly we can look at enhancing some
2 of the information that we provide on our website. My hope
3 is that each of the award organizations will showcase the
4 award on their own website and provide some additional
5 information, because I think that part of it is that it's
6 an opportunity for each of the organizations to, in a
7 sense, brag a little bit. But sharing this information
8 with your peers excites them to the possibility of what can
9 be done in these communities to really improve lives. You
10 all talk in very straightforward terms, and that's very
11 encouraging too, about improving the lives of those you
12 serve, and you cite very concrete examples of how you've
13 done that, through housing, through jobs, through improved
14 social networks, and that's really at the core of SAMHSA's
15 vision and mission.

16 So I think we are singing from the same song
17 sheet when we talk about that. So any effort that we can
18 have to mutually reinforce each other's good work, I think
19 we should pursue that.

20 DR. CLINE: Ken?

21 MR. STARK: I also want to say thank you to all
22 of you for coming and for presenting, and obviously for the
23 good work you do.

24 Let me throw out sort of a rhetorical question.
25 I'm not asking for a response right now. This is kind of

1 the business side of Ken Stark, the cheapskate side, the
2 investor side, the purchaser side. One of the issues
3 around evidence-based practices for me as a purchaser has
4 always been about is there value to the implementation of
5 this EBP. The question is, well, how do you determine
6 that? Well, the only way that I could determine that would
7 be to know what my outcomes were prior to implementation,
8 and my unit cost per consumer prior to implementation, and
9 compare that to my outcomes post-implementation, as well as
10 my unit cost post, and try to determine whether or not
11 there is value in that investment, that the increased
12 outcomes were somewhat comparable to the increased
13 investment in terms of dollars.

14 I don't know if any of you have actually looked
15 at all of that from that level, but I would encourage you
16 to, because I've got to tell you if we are truly going to
17 get more and more people to implement a broader array of
18 EBPs, that it's going to come down for the purchasers to is
19 it worth it, is there value in that implementation.

20 DR. HEPBURN: May I respond to that real
21 quickly? We started an outcomes measurement system
22 statewide last October, and prior to that we just had more
23 anecdotal type of information. Our outcomes measurement
24 system will be able to do that. So I should be able to
25 come back in a couple of years and say this is what was

1 happening before the individual went into an evidence-based
2 practice, this is what's happening subsequent, and if the
3 cost isn't there, that's why we won't be doing the
4 evidence-based practice anymore, because the question you
5 just asked is what legislators ask. When we go to our
6 budget hearings, that's what we have to defend. This is
7 all really nice, but how do you know it works?

8 DR. CLINE: I think with that comment we will
9 close. I'd like to thank you all. It was inspirational.

10 (Applause and standing ovation.)

11 DR. CLINE: In addition to being inspirational,
12 informative and all those good things, that was just fun.

13 (Laughter.)

14 DR. CLINE: That was really fun. So thank you
15 all. That's a perfect note for us to close out that
16 segment.

17 Kevin, thank you for your leadership as well in
18 terms of bringing people to the table.

19 (Applause.)

20 DR. HENNESSY: I just wanted to mention that
21 when this meeting officially adjourns, there will be an
22 opportunity for some additional pictures with Dr. Cline in
23 the library. So don't disperse to the winds quite yet.
24 Thanks.

25 DR. CLINE: Thank you.

1 At this time we will move to our public comment
2 section. We have one person who signed up, Jan Towers.

3 Jan, if you could move to the microphone and
4 please identify yourself and your organization. Thank you.

5 MS. TOWERS: I am Jan Towers. I'm director of
6 health policy for the American Academy of Nurse
7 Practitioners. First I would like to say that I've been
8 very impressed too listening to all these success stories,
9 and it's a wonderful way to plant seeds and get other
10 people to understand how they might be able to do things
11 that will help across the nation.

12 I would just like to plant one more seed. One
13 of the things that I've noticed as I've listened to the
14 conversations for the past two days is the fact that there
15 is no mention made of a group of providers that can make
16 significant contributions to the kinds of things you're
17 doing, and they're the advanced practice nurse
18 practitioners who are prepared both in primary care and we
19 have specialists in psych mental health. These are
20 prescribers. They are able to prescribe medications. They
21 are in most instances independent practitioners who are
22 able to step out and work in your communities, and
23 particularly in communities where you have large numbers of
24 vulnerable populations or you have under service. This is
25 a group of people who are, because of their nursing

1 framework, very attuned to this kind of activity, go to
2 these places and do stay.

3 So while there's a lot of discussion about
4 M.S.W.s and psychologists and physicians, I didn't hear the
5 nurse word in there very often, and I certainly didn't hear
6 the nurse practitioner piece. So I would like you to think
7 about incorporating that into your thought processes when
8 you're doing things.

9 I would just point out that there are 150,000
10 of us, and as I've pointed out, we are prescribers. We do
11 have a specialty of psych mental health. We are
12 particularly vested in prevention. That's our mantra. So
13 health promotion and disease prevention is something you
14 hear discussed around us all the time. So we're very much
15 into that front-end piece, as well as being able to treat
16 people that have mental health problems.

17 The other thing is that we're very holistic in
18 our care. Every nurse practitioner knows you don't just
19 stop with the disease entity, number one; the individual,
20 number two. You look at the family and the community. So
21 the mindset that nurse practitioners have very much fits
22 into the framework with what you're doing here at SAMHSA.

23 So I would hope that you would see this as a
24 group that you want to incorporate more fully, and I'm
25 going to plant that seed with you right now. Thank you.

1 DR. CLINE: Thank you for that comment.

2 Now we will turn to our co-chair, Governor
3 Aiona, for closing comments.

4 Governor?

5 MR. AIONA: Thank you, Dr. Cline.

6 I think I can speak on behalf of everyone, but
7 I'll give everyone a chance, if you don't mind -- do we
8 have time for that, just very briefly? I think I speak for
9 everyone when I say this was a great meeting. As I stated
10 in the beginning, you're all very unique and a very
11 interactive group, and you can tell from the comments and
12 the questions and everything else that was done this past
13 day and a half that we did get a lot accomplished.

14 I think the recommendations portion was
15 excellent. We've come away with some great
16 recommendations, and I think the three whose terms are
17 expiring at the end of the year, they're going to want to
18 see some follow-through on this, so we're going to have to
19 make sure that we do follow-through on that. We're going
20 to miss you three. I know Ken is going to miss all of you,
21 and so is Dr. Gary.

22 But I'd open it up if any of you want to make
23 any closing comments at this time.

24 MS. SULLIVAN: I thought it was so interesting
25 that what I heard today was the word "prevention" a lot

1 more than what we have taken, I know as a council, as our
2 agenda. I heard so much more, especially from the
3 providers, about the importance of us providing more
4 materials I guess on prevention, but that was a buzzword.
5 Again, I want to thank you so much for reminding me about
6 stigma as also an obstacle to care. It's something that
7 should always be ever-present on our mind and,
8 unfortunately, on the agenda.

9 We've discussed this before in other meetings,
10 but thank you again for reminding me of the importance of
11 that as a huge obstacle to care that we also must continue
12 to address.

13 And I'm still not leaving.

14 (Laughter.)

15 MR. AIONA: Anyone else?

16 (No response.)

17 MR. AIONA: If not, Dr. Cline, thank you again.

18 Well run.

19 DR. CLINE: Meeting adjourned. Thank you.

20 (Applause.)

21 (Whereupon, at 11:20 a.m., the meeting was
22 adjourned.)

23

24