

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

42nd Meeting

Monday,
September 10, 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.

C O N T E N T S

PAGE

Welcome and Opening Remarks

Terry L. Cline, Ph.D., Chair, SAMHSA National
Advisory Council and Administrator, SAMHSA 6

James R. Aiona, Jr., Lieutenant Governor,
Hawaii, and Co-Chair, SAMHSA National
Advisory Council 6

Consideration of the Minutes from the March 7-8,
2007 SAMHSA Council Meeting 8

Administrator's Report

Terry L. Cline, Ph.D. 8

Update on SAMHSA's Suicide Prevention Activities

Mark A. Weber
Director
Office of Communications, SAMHSA 16

Consumer Presentation

Karen M. Marshall
Co-Chairperson
National Suicide Prevention Lifeline
Consumer/Recipients Subcommittee 20

Discussion 29

Update on SAMHSA's Workforce Development Activities

Beverly Watts Davis
Senior Advisor to the Administrator, SAMHSA 50

Consumer Presentation

Larry Fricks
Director
Appalachian Consulting Group 56

Discussion 65

C O N T E N T S

	PAGE
Helping America's Youth	
Larke Nahme Huang, Ph.D. Senior Advisor on Children, SAMHSA	72, 88
Charles Reynolds Center for Substance Abuse Prevention, SAMHSA	76
Consumer Presentation	
Leah Truitt National Vice President of Community Service Family, Career, and Community Leaders of America	82
Discussion	90
SAMHSA's Role in Ensuring That the Physical and Mental Health Needs of Returning Veterans and Their Families are Met	
Arne Owens, M.S. Senior Advisor to the Administrator, SAMHSA	111, 137
A. Kathryn Power, M.Ed. Director Center for Mental Health Services, SAMHSA	119
Discussion	
A. Kathryn Power, M.Ed., and Arne Owens, M.S., Moderators	141
Public Comment	161
Presentation of Awards to Retiring National Advisory Council Members Gwynneth A.E. Dieter, Barbara Huff, and Kathleen Sullivan	
Terry L. Cline, Ph.D.	171

1 P R O C E E D I N G S (9:05 a.m.)

2 DR. CLINE: Good morning, everyone. I'd like
3 to welcome you to the 42nd SAMHSA National Advisory Council
4 meeting here today on September 10th.

5 I'd like to start by recognizing our vice
6 chair, Lieutenant Governor Aiona.

7 MR. AIONA: Good morning. Aloha.

8 DR. CLINE: Good morning.

9 And I will turn it over to you for
10 introductions.

11 MR. AIONA: Thank you. I just want to say good
12 morning again to you, Dr. Cline, and everyone else here.

13 We have a real tight schedule. So I'm going to
14 ask everybody to just introduce themselves for the record,
15 and we'll start here from my right with Mr. Stark.

16 MR. STARK: Ken Stark, Director of the Mental
17 Health Transformation Project, Office of the Governor,
18 Washington State.

19 MS. SULLIVAN: Kathleen Sullivan, journalist.

20 MS. DIETER: Gwynneth Dieter from Colorado and
21 Belize.

22 DR. LEHMANN: Larry Lehmann representing the
23 Department of Veterans Affairs.

24 DR. CLARK: Westley Clark, Director of the
25 Center for Substance Abuse Treatment.

1 MS. HUFF: Barbara Huff. I work part-time for
2 the Federation of Families for Children's Mental Health and
3 do consulting work on the other part-time. Good to be
4 here.

5 MS. POWER: Good morning. Kathryn Power,
6 Director of the Center for the Mental Health Services.

7 DR. GARY: Faye Gary, professor, Case Western
8 Reserve University, Cleveland, Ohio.

9 MS. KADE: Daryl Kade, Director of Policy,
10 Planning, and Budget and the Executive Director of NAC.

11 MR. AIONA: Diane, could you introduce yourself
12 for us?

13 MS. HOLDER: Yes. Diane Holder, President,
14 UPMC Insurance Services and Health Plan.

15 MR. AIONA: Thank you. Diane is joining us via
16 telephone. So welcome. And don't forget to chime in when
17 you want to now. Okay, Diane?

18 MS. HOLDER: Thank you.

19 MR. AIONA: Doctor, I'll turn it back over to
20 you.

21 DR. CLINE: And Ms. Vaughn, would you like to
22 introduce yourself?

23 MS. VAUGHN: Thank you. Toian Vaughn, the
24 SAMHSA committee management officer, as well as I am the
25 federal designated official for the SAMHSA council.

1 DR. CLINE: Thank you very much.

2 Also I'll note that Mrs. Bush and Dr. Kirk are
3 unable to join us today, but I'd like to acknowledge them
4 as members of the council as well.

5 If you'd please now just take a look at your
6 minutes. Hopefully you've had time to review those. I'll
7 entertain a motion to accept the minutes.

8 PARTICIPANT: So moved.

9 PARTICIPANT: Second.

10 DR. CLINE: We have a motion to accept and a
11 second. Any comments, edits, changes, anything at all?

12 (No response.)

13 DR. CLINE: Hearing none, all those in favor of
14 accepting the minutes, please say aye.

15 (Chorus of ayes.)

16 DR. CLINE: Thank you. The minutes are
17 accepted.

18 For the Administrator's report, I'd like to
19 highlight just a few items and I'll move through those
20 quickly. I'd like to start by just mentioning the
21 Department's participation, SAMHSA's participation, in
22 response to the Virginia Tech tragedy which took place just
23 a few months ago. I think as everyone is aware, President
24 Bush had asked three of his cabinet members to travel the
25 country, gather information, to really frame questions that

1 had been raised by the tragic event itself. So we had
2 Secretary Leavitt, Attorney General Gonzalez, and Secretary
3 Spellings who traveled to 12 sites across the country
4 holding forums with Governors and members of health
5 departments and law enforcement and education to frame
6 questions for the President related to the incident.

7 All of that information was compiled and put
8 together in a report which Secretary Leavitt, as the lead
9 for that effort, presented to the President. We'd be happy
10 to provide a copy of that to council members, if you're
11 interested in that.

12 The report also includes a number of
13 recommendations for various departments within the federal
14 government. The intent of the report was not to question
15 the specifics at all about what happened in Virginia, but
16 really to look at the larger questions that were raised.
17 So Governor Kaine from Virginia was involved in doing his
18 own kind of investigation of that incident. So it didn't
19 make sense this to duplicate those efforts. As a result of
20 that, there were several recommendations on the part of the
21 federal government that came about from this information-
22 gathering process. There are some recommendations specific
23 to Health and Human Services and others for Justice and
24 also for Education.

25 Secretary Leavitt has asked SAMHSA to be the

1 lead in kind of tracking HHS' involvement in this process
2 and over time to make sure that we stay on target with
3 those recommendations, and I'm happy to say that we are
4 doing that, enlisting Director Power and her staff to take
5 primary responsibility for that.

6 Some of the specifics, in terms of SAMHSA's
7 involvement. One has been to produce a video that really
8 is kind of a public service announcement encouraging young
9 people to recognize the signs, early symptoms of mental
10 illness, and then to reach out to those individuals and to
11 encourage those individuals to seek help. There was
12 concern that the pendulum could swing in the opposite
13 direction, that people would actually become fearful about
14 identifying their own needs or identifying needs of family
15 members as a result of that tragedy. So that PSA has been
16 developed. It's "What a Difference a Friend Makes." It's
17 an outstanding PSA.

18 We also targeted college-age population for a
19 number of materials. Some of those were sent specifically
20 to Virginia Tech, and the rest of those are available
21 across the country. So that's a huge effort that is
22 underway as well.

23 We have a couple of initiatives that we are
24 identifying within those initiatives what particular role
25 we might play in identifying, again, young adults in the

1 Safe Schools/Healthy Students Initiative, which is a large
2 grant program. Are we doing everything that we can do
3 within that?

4 Then there are other responsibilities for CDC
5 and NIMH and others. But again, we as an agency here will
6 be following up with that.

7 Let me start by saying when I walked into the
8 room this morning, I was a little bit disoriented because
9 the last meeting was my first one. I thought maybe they
10 alternate every other time, go back and forth like that.
11 But I was told that was not the case. Then I thought,
12 well, maybe it's a metaphor for change. You know, we can
13 change. We do change, and we'll just keep people guessing
14 about what the change will be. But it wasn't anything that
15 deep or that meaningful. We had some technical
16 difficulties that were identified early. So we switched to
17 this side of the room. So my apologies if it's a little
18 bit disorienting for some of you who are used to meeting on
19 the other end of the room. But that's the reason we're
20 down here today, and hopefully that will work for you all.

21 But when I first met with you, we were just
22 beginning the process of reauthorization before Congress,
23 which is really identifying the focus and the meaning, what
24 authority SAMHSA has to carry out its vision and its
25 mission. That process is continuing. We've had the

1 congressional hearings and the process is fully engaged
2 right now.

3 Joe Faha, our Legislative Director, has been
4 doing a fantastic job of engaging with members of Congress
5 and the staff to make sure they're fully informed of
6 SAMHSA's kind of participation and role in this process,
7 and it has gone very, very smoothly. So we would hope that
8 that will continue throughout this legislative session.

9 Also with the budget, we're just at the
10 beginning stages of our budget. The budget was submitted
11 by the Secretary this last Friday to the White House, and
12 we will find out the President's response and the
13 President's budget right after the State of the Union
14 Address.

15 But thank you for your participation in that
16 process here at the last meeting when you provided input
17 for us which helped inform our formulation of the budget as
18 we forwarded that to the Department, which has now
19 forwarded it on to the President.

20 Speaking of your input, this particular council
21 meeting is structured a little bit differently. We have
22 worked hard to incorporate your suggestions from the last
23 council meeting. So we have allowed more participation
24 from people who are non-staff members, people who may be
25 consumers of our services or may be intimately involved in

1 the delivery of those services so that you will have more
2 of a sense of how our work relates to others, whether it's
3 at the community level or at the state level or at the
4 individual level. So you'll notice a little bit of shift
5 in there.

6 We have also, I hope, allowed ample time for
7 discussion, and if we find out that we have not provided
8 that time, I hope that you will provide feedback about this
9 particular meeting so we can continue to tailor that to
10 meet your needs as well.

11 At this point, I'm going to turn it over, so
12 you'll hear more specifics on the structure of the meeting
13 for today, again to the co-chair, Lieutenant Governor
14 Aiona.

15 MR. AIONA: Thank you, Dr. Cline. I just want
16 to actually try to make it as clear as I can on the
17 structure of the meeting. I hope you all had a chance to
18 look at your agenda, and if you haven't, take a look at it.

19 But it's a full day and a half of updates on issues that
20 we did discuss at the last meeting.

21 As you can see, there's more interaction from
22 consumers and workers at SAMHSA on these various issues,
23 and we will have an opportunity as a council to ask
24 questions and to interact with the presenters. If we can
25 do it at the end of the presentation, there's time set in,

1 as you can see, for us to really be active in it. Of
2 course, if you do have a question, we can't hold you back.

3 This is a great council. If you have a burning question
4 during the presentation, then go ahead and ask it.

5 But I also want to remind you, because I think
6 we talked about this at the last meeting, about our input
7 and our recommendations, that we feel a burning desire to
8 give recommendations to the Director and to the Department.

9 We have some opportunity tomorrow, if I can highlight that
10 for you. In the beginning of the session tomorrow, we'll
11 have an opportunity to come to some consensus on some of
12 the recommendations we might have, some of the suggestions
13 we might have because I think we are very interactive and
14 we work well as a group. So if we can come to some
15 consensus on some of these recommendations and suggestions
16 that we have, we have an opportunity at the beginning and
17 also at the end, I believe, of the session tomorrow to make
18 it happen.

19 I guess what I'm trying to say -- I'll try to
20 put it as succinctly as I can. It's not necessary for us
21 today at the end of these presentations to come to some
22 kind of consensus in regards to these recommendations and
23 suggestions that we have. We've got time tomorrow. But
24 please raise them, again, in the time allotted here so we
25 can stay on agenda.

1 With that, I'll turn it back to Dr. Cline.

2 DR. CLINE: Great, thank you. Any questions
3 about the format or any comments about the structure so
4 far?

5 (No response.)

6 DR. CLINE: Thank you.

7 I also would like to thank you. I know several
8 of you made comments about the data strategy, and I
9 appreciate your comments, and wherever possible, we
10 incorporated those comments and made changes where
11 appropriate based on those. So those were very helpful,
12 and I appreciate you taking the time to do that.

13 The data strategy itself is currently under
14 review with OMB and ONDCP. After a great deal of work and
15 a great deal of time, Dr. Broderick has kind of brought
16 that all together and pulled it together in a really
17 meaningful fashion. So thank you, Dr. Broderick, for that.

18 Those comments are under review by other entities right
19 now. So thank you for taking the time to do that.

20 I also would like to recognize Jim Stone who is
21 here representing Dr. Grim on the part of IHS, and I also
22 would like to recognize Judy Cushing from the Oregon
23 Partnership. Judy, would you just stand up or raise your
24 hand there? Thank you very much.

25 And I know that throughout the day we have

1 people who come and go, and we will make every attempt, at
2 appropriate times, to recognize those individuals as they
3 come on the scene.

4 At this point, I would like to move to the very
5 first presentation with Mark Weber taking the lead, and if
6 he's back there working on his presentation right now, we
7 have caught him a little bit ahead of schedule. So Mark,
8 as I'm sure most of you know, is the Director of the Office
9 of Communications here at SAMHSA.

10 Mark, I'll turn it over to you.

11 MR. WEBER: I don't know how you knew I was
12 still back there working on it, but yours was ready.
13 Right? Thank you, Toian, for helping on that.

14 Good morning. It's good to see you all. Great
15 to be here again.

16 This morning we're going to talk a little bit
17 about the suicide prevention matrix area. I was appointed
18 the lead of that area within SAMHSA, and I guess that
19 happened around October of 2006. I have to say I could not
20 do this responsibility without the support of Kathryn Power
21 and Westley Clark and Dennis Romero and Richard McKeon here
22 to my right. I often call him the brains of the operation.
23 He's a special advisor for suicide prevention here at the
24 Center for Mental Health Services.

25 As I mentioned, the program area primarily

1 resides within CMHS, but all three centers are focusing
2 increased attention on suicide prevention: CMHS, clearly
3 through the mental health system transformation; CSAP,
4 through the Strategic Prevention Framework grants; and
5 CSAT, through some of the substance abuse treatment
6 protocols and some special papers on the interrelationships
7 between suicide and substance abuse.

8 Funding in '07 for suicide prevention
9 activities is \$36.1 million, including \$26.7 million for
10 the Garrett Lee Smith Memorial Act programs.

11 According to the Centers for Disease Control,
12 there were 32,439 deaths by suicide in 2004, representing a
13 slight increase from 2003. I don't know if any of you saw
14 in the media recently, there was the single largest one-
15 year increase in suicides among young people from 2003 to
16 2004.

17 MS. HUFF: (Inaudible.)

18 MR. WEBER: What I'll do is I can get you the
19 press release, and you can have the exact specific data.
20 Richard may actually have it off the top of his head, but
21 I'll just make sure I --

22 MS. HUFF: You just mentioned a figure.

23 MR. WEBER: Oh, I'm sorry. That was 32,439 in
24 2004.

25 MR. AIONA: Barbara, you need to turn your mike

1 on when you speak.

2 MR. WEBER: Interestingly enough as well, we
3 collect information about suicide and suicide thoughts
4 through the National Survey on Drug Use and Health, and the
5 most recent data we have from 2004 shows that approximately
6 900,000 young people 12 to 17 had made a plan to commit
7 suicide during their most recent episode of serious
8 depression, and 712,000 attempted suicide during such an
9 episode of depression. We have added some additional
10 questions to the National Survey on Drug Use and Health to
11 get at even more of the issues around young people and
12 adults too and their thoughts about suicide and actual
13 attempts.

14 Overall, again a number that I think most of
15 you are familiar with, 90 percent of people who die by
16 suicide have a treatable mental illness or substance use
17 disorder.

18 What are we doing about all of this here at
19 SAMHSA? We have a two-year action plan that was finalized
20 a year ago in December. We have a matrix workgroup across
21 the entire agency. It's a work in progress and the
22 development continues as key milestones are met. That
23 action plan is actually part of your packet, and we have a
24 probably 25-page working agenda that sort of keeps track of
25 all the different steps that we need to be taking inside

1 SAMHSA and outside of SAMHSA to achieve that two-page plan.

2 We continue to award grants, which are the
3 primary vehicle for getting the work done, the Garrett Lee
4 Smith, the Suicide Prevention Hotline, Suicide Prevention
5 Resource Center, and one of the things that's near and dear
6 to my heart is we're working with the Ad Council on a
7 suicide prevention public education campaign.

8 We're also working in partnership with the
9 Centers for Disease Control, NIMH, and other federal and
10 private partners through the Federal Working Group on
11 Suicide Prevention, which is part of the Federal Mental
12 Health Action Agenda, the Federal Executive Steering
13 Committee, bringing all the different components of the
14 federal government together to help ensure alignment around
15 the suicide prevention activities.

16 Some of our key next steps is to establish a
17 National Action Alliance to implement the National Strategy
18 for Suicide Prevention. I hope all of you are familiar
19 with the National Strategy to Prevent Suicide, 68 specific
20 objectives organized around 11 goal areas.

21 We're also going to utilize some findings from
22 some studies we've done with outside groups about what are
23 the priorities for the Action Alliance to help us
24 prioritize what we're going to focus on initially from the
25 action plan.

1 We're also working on implementing a cross-site
2 evaluation of the Garrett Lee Smith suicide prevention
3 programs, so again, inform the process so we can continue
4 to improve how we manage and run those grant programs.

5 Overall, again some recent news, continue to
6 enhance the quality of the Suicide Prevention Crisis
7 Center. There's an ongoing assessment of that program.

8 Now, it is actually with great pleasure that I
9 am going to introduce to you Karen Marshall, and she's
10 going to tell us more about how the Lifeline, suicide
11 prevention hotline, makes a difference every day in the
12 lives of those at risk for suicide. She is a career
13 journalist with extensive experience in print, broadcast,
14 and web-based reporting, and after losing her father and an
15 uncle to suicide, she became involved in prevention
16 efforts, first as a volunteer and later in full-time
17 professional capacities. She's helped to advance the work
18 of nonprofit suicide prevention organizations since 1990.

19 After Karen speaks and during Karen's
20 presentation, we invite you to ask questions, interrupt.
21 We have Richard here as well, and we will look forward to a
22 good dialogue with you all. We need direction and
23 guidance.

24 Karen?

25 MS. MARSHALL: Thank you very much. I

1 appreciate the opportunity to be here, especially today
2 because today is World Suicide Prevention Day. So around
3 the globe, there are activities going on to help to raise
4 awareness about suicide and its impact on our globe where
5 more than a million people a year end their lives. Here in
6 the U.S., World Suicide Prevention Day is part of National
7 Suicide Prevention Week, which we are now in the midst of,
8 and every year more and more activities are going on around
9 the country by people who want others to understand the
10 impact of suicide before it ever gets to them. It's a
11 wonderful outreach. So it's my privilege to be here today
12 talking with you on such an important day.

13 I've been involved in suicide prevention, as
14 Mark mentioned, starting out as a volunteer, for about 17
15 years now. In that time, I've seen the idea of preventing
16 suicide go from what looked like a great, big glacier --
17 nothing was moving. It was just a big, cold presence in
18 the middle of our lives -- to beginning to show some signs
19 of becoming an avalanche. And I kind of like that. You
20 know, you see the pictures of the great, big hunks of ice
21 falling off of glaciers, and one by one, as we take on
22 these new projects, the Lifeline Network, the Suicide
23 Prevention Resource Center, the state task forces, those
24 are those big chunks of ice falling. And things are
25 beginning to move and there are some positive things going

1 on.

2 Actually more is going on now than I ever could
3 have believed 17 years ago as I was just getting started.
4 My mentor and dear friend, Iris Bolton, the Director of the
5 Link Counseling Center in Atlanta, has been my guide
6 through all of this. She's the one who hauled me kicking
7 and screaming up on stage one time and said, you know,
8 Karen, you've got your own voice. Stand up there and talk.
9 I'm like, I don't think so. But I did and I have and it's
10 been a great pleasure.

11 In that time, I've been involved in starting
12 and facilitating support groups for survivors. That was a
13 valuable, valuable thing for me to find. It helps people
14 immediately when they need it to try to understand what's
15 happened to them and also to understand the magnitude and
16 also to understand that they can heal. In Iris' words, it
17 was rarely anything that we said that helped people to
18 heal. It was simply the fact that we were there putting
19 one foot in front of the other, living our lives, looking
20 like normal people again. That life is changed forever but
21 it can still be good.

22 From there, I got involved in a lot of
23 awareness and prevention speaking. I did a lot of
24 training, a lot of community presentations, and that's
25 still something that I enjoy doing the most, informing

1 people about what this is and helping them to find some
2 hope that they can be part of the solution.

3 I got involved in state advocacy starting in
4 Virginia. I moved away from Atlanta in 1996 and took
5 everything that Iris had taught me and moved to Virginia.
6 One of the first things that happened is Virginia became
7 the first state to adopt a resolution recognizing suicide
8 as a serious health issue, which was mirrored from the
9 federal resolutions that had been passed the year before.
10 That was thanks to a state senator by the name of Bill Mims
11 who listened and took this on and championed everything we
12 asked him to do, including getting funding for suicide
13 prevention the first year we asked for it.

14 I've been privileged to work with state
15 coalitions that formed in Virginia, Michigan, and Illinois.
16 They're all running wonderfully, and I think they're doing
17 great work.

18 From there, that's where I made my move to
19 full-time work. I went to work for the Hope Center, which
20 was the originator of the Crisis Line Network and had the
21 number 1-800-SUICIDE.

22 If I may have an aside here just for a moment,
23 I know, probably not thoroughly, but know very well, what
24 all of you went through in getting the number 1-800-SUICIDE
25 staying live and being available for people to answer

1 calls. It's so important. It's just a number that never
2 could go away. So 1-800-SUICIDE, along with 1-800-273-TALK
3 -- I think we're reaching a lot of people. And I
4 appreciate everything that all of you did, all of you went
5 through to ensure that that number was going to be there
6 for the people who needed it. I don't know what the future
7 holds for us, but I hope it's going to be good. But that's
8 been a priority for me.

9 It's now my pleasure to work for the American
10 Association of Suicidology based here in D.C. I'm coming
11 up on the end of my second year with them where I'm a
12 program development director. AAS is one of a number of
13 national suicide prevention organizations that meet and try
14 to collaborate through the National Suicide Prevention
15 Council. It's a very important thing. AAS is sort of an
16 umbrella organization for five divisions. One is research
17 where we try to help translate research into practical use
18 for people in the outside world. Prevention specialists --
19 we try to provide up-to-date information, up-to-date
20 materials for them. We work with clinicians to sharpen
21 their skills in recognizing suicide and how to prevent it.
22 We accredit crisis centers and have a number of them as
23 members. And a Survivor Division which is growing and
24 growing as people look for a way to become involved as a
25 way of dealing with what's happened in their lives.

1 I'm very pleased right now to tell you very
2 briefly about a project that I've worked on real hard.
3 It's coming to fruition. The Federal Railroad
4 Administration and the Federal Transit Administration are
5 funding a five-year project to understand the magnitude of
6 suicides that occur on the nation's rail systems and to
7 begin to come up with some prevention programs for that.
8 That's our project, and we're moving into the second year
9 of that which is going to be the real research-driven part
10 of that, and we're hoping to come out with really strong
11 partnerships with the railroads.

12 What I love about this is it's the first time
13 that I can think of that an industry came to the suicide
14 prevention community and said we have a problem. Please
15 help us. My comeback to that is if the National Rifle
16 Association, NRA, would do something like that, the world
17 might be a different place. And I can hope for it. But
18 we're starting with the railroads.

19 Also, we are piloting a workplace-based suicide
20 prevention program that is based on the Air Force model.
21 Again, we're working with another federal agency that's
22 probably going to be the workplace site for what we hope
23 will be a grant issued through NIH. We'll be applying for
24 that next month.

25 I'm a member of the University of Michigan's

1 Depression Center. It's the only one of its kind in the
2 country, but it won't be for long. It's a concept that's
3 being spread. It's a multidisciplinary look at dealing
4 with depression. U of M has just been a leader in that,
5 and I've been a member of their national advisory board
6 from the very beginning because Dr. John Graydon, who is
7 the Executive Director, realized that you can't talk about
8 depression without talking about suicide. So he wanted
9 somebody who was involved in the suicide prevention
10 movement to be part of that.

11 Then there's the Lifeline, one of my favorites.

12 I was thrilled to be asked to be on one of the
13 subcommittees from the very beginning of the Lifeline
14 Network. I now co-chair the -- a new name --
15 Consumer/Survivor Committee. It used to be
16 Consumer/Recipients, and the decision was made at our last
17 meeting to change it to Consumer/Survivor because it seemed
18 to take in more of what we're aiming at. One of those
19 things is working more with people who have attempted
20 suicide and survived it. So we felt like the word
21 "survivor" was an important thing. So I'm now co-chairing
22 that with Eduardo.

23 The big joke is that I'm usually the stand-in
24 on one committee or another for somebody. I've been
25 Eduardo twice now. I was Dr. Lanny Berman one time at a

1 steering committee meeting. Everybody says that's fine.
2 As long as you're here, it's okay. So I'm the official
3 stand-in.

4 I think the thrust of what we've done, not only
5 with attempt survivors, has also been outreach to Native
6 Americans and the critical needs there and to older
7 Americans. I would say that in the next five years of the
8 grant that has just been reissued, one of the things I
9 think we need to look at seriously is finding sustainable
10 funding for crisis center operations because they have
11 taken on a load of work with these national hotlines. They
12 haven't asked for anything. They've taken it on because
13 that's what they do, and I think we need to figure out a
14 way to make them not worry about meeting their budgets
15 every month. They provide such a crucial service.

16 To kind of wrap up this part of it -- and I do
17 hope you have some questions for us afterwards -- how did I
18 get here? As Mark told you, I lost my father to suicide.
19 That was in 1973. I was 17 years old. I was a senior in
20 high school. If you think we don't talk about suicide now,
21 we really didn't talk about it in the '70s. No one ever
22 came up to me and said, gee, Karen, this happened in our
23 family and this helped and this didn't, but you can get
24 through it. No one said anything to us at all. So it kind
25 of felt like we were the only family on the planet that had

1 ever gone through it. You knew somehow intuitively that
2 couldn't be true, but no one talked about it.

3 So I kind of went on with my life. I went to
4 school. I got married, started a family, started my
5 journalism career. And 17 years after my dad's death, his
6 only brother, my uncle, killed himself less than a mile
7 from where my dad died. That brought back everything that
8 I couldn't do and didn't do in 1973. I had to heal myself.

9 I had to find some way to go on living myself because it
10 seemed overwhelming at that point.

11 That's where I found out that there were
12 support groups for survivors, and it was like somebody
13 threw me a life ring to be able to sit with other people
14 and talk about what happened and to understand and for them
15 to be able to look at me and say, you know, Karen, I
16 understand what you mean. And I knew that they knew. What
17 a terrible way to know, but at least we could be in it
18 together.

19 Then, as I told you, I went on to work with
20 Iris.

21 As I talk about my personal story and what's
22 happened in my life, I'm back to the glacier again because
23 I still work with survivors very closely in the immediate
24 aftermath of a suicide in their family and I still hear
25 them say, as my family did 34 years ago, if I only would

1 have known, if I had known what the warning signs were, if
2 I had known where to go for help. In 34 years, that hasn't
3 changed, and I think that's the next piece of the glacier
4 that needs to fall because we know that the more people
5 know about preventing suicide, the closer they are to the
6 person who's at risk, the more help can be offered to them.

7 And it does take all of us. It takes all of us in every
8 walk of life in anything that we do to just know and to be
9 able to help.

10 And that's my story.

11 DR. CLINE: Thank you very much, Karen. Thank
12 you for sharing your story, as well as all the incredible
13 work that you're continuing to do.

14 MS. MARSHALL: Thank you.

15 DR. CLINE: Questions and comments from the
16 council members? Yes.

17 DR. LEHMANN: Again, thank you for your
18 comments. Also, I want to thank the SAMHSA/CMHS group and
19 Rich McKeon for the tremendous help they've given to the
20 Department of Veterans Affairs.

21 I have a handout that I'm going to pass around
22 to everyone except Gwynneth who got hers already. These
23 are our new suicide prevention pocket cards. We wanted to
24 revise them. We had a version before that talked about
25 risk factors and actions to take. We revised it. So we

1 also have protective factors, and we also added the
2 1-800-273-TALK hotline number to that. We now have, as of
3 July 26th, a module on that for veterans or family members
4 of veterans to seek support. We're just tremendously
5 pleased and grateful for that. That's getting a lot of
6 use.

7 We just finished training suicide prevention
8 coordinators two weeks ago, one in every VA medical center,
9 and their first task is to participate in VA's Suicide
10 Prevention Awareness Week educational activities that
11 actually are going on right now.

12 So, again, we wanted to tell you some of the
13 things that we're doing for suicide prevention across the
14 VA system and to thank you for your support in our being
15 able to do that.

16 DR. CLINE: Great. Thank you.

17 Ken?

18 MR. STARK: I just had a question about what
19 you're aware of that's going on relative to training, if
20 you will, other gatekeepers, whether it be the primary care
21 system, the public health system, the alcohol/drug system,
22 the children's administration systems, the older adult
23 long-term care systems, training them in identifying some
24 of the risk factors and some of the strategies for early
25 screening.

1 MS. MARSHALL: That's a really good question.
2 It's something that's going on kind of in bits and pieces
3 around the country.

4 What I can tell you is the change in attitude
5 about organizations like those that you mentioned or like
6 schools to having people come in and teach gatekeeper
7 training to, say, school counselors, teachers, people in
8 behavioral health facilities, people in all the different
9 areas that you just enumerated. It used to be if you came
10 in and said, we'd like to do a presentation on preventing
11 suicide, they'd say, you're not going to say that word
12 here. Now they're saying, when can you get here and what
13 can you teach us?

14 So I think we need to respond to the request,
15 to the need that people are expressing to want to know
16 more. Even though it's a little scary at first, I think
17 most people who learned to become gatekeepers feel a sense
18 of hope and a sense of confidence after they've had the
19 training and are willing to put it to use.

20 So it's a great question. I don't know of a
21 concerted effort to do it. There have been some really
22 good training programs developed independently around the
23 country, and we all tend to work together pretty well.

24 DR. McKEON: There are a couple of things I
25 could add to that. The gatekeeper training is the single

1 most frequently utilized program within the Garrett Lee
2 Smith grant program. So gatekeeper training is taking
3 place in virtually all of the 55 college campuses who are
4 currently receiving funding through that program. And it
5 is also taking place in a great majority of the 31 states
6 and 7 tribes and tribal organizations who are receiving
7 funding through Garrett Lee Smith.

8 As Karen mentioned, there are a number of
9 different approaches to gatekeeper training that have been
10 utilized. We'll be getting additional information about
11 the impact of these trainings through the cross-site
12 evaluations that we're undertaking that received Office of
13 Management and Budget clearance back in May. So we will
14 begin to be receiving data on a larger scale in just a
15 month or so.

16 We have also supported evaluation of gatekeeper
17 training activities through our Adolescents At-Risk grant
18 program, including one very promising project in Cobb
19 County, Georgia, affiliated with the University of
20 Rochester, where our grant is a follow-up to a randomized,
21 controlled trial that the National Institute for Mental
22 Health had done, and we're starting to get some important
23 information.

24 Then one other thing that I would also mention
25 because Karen spoke very eloquently about the importance of

1 getting out information about warning signs. One
2 additional thing that we've done in that area is that we
3 have pocket cards that include the warning signs for
4 suicide, as well as the 273-TALK number. Over 500,000 of
5 them have gone out to various places in the country. We've
6 recently printed an additional 500,000 of them. So we're
7 trying in multiple ways to get out the information about
8 the warning signs for suicide and about what to do.

9 MR. STARK: My follow-up is tied to -- as I
10 look around, all of us silo folks, mental health,
11 alcohol/drugs, primary care, or whatever -- each of us have
12 our agendas, and we're looking at trying to get the other
13 systems to pay attention to our issues talking about
14 suicide prevention or alcohol/drug prevention or
15 intervention or mental health services. There are many,
16 many initiatives pushing, say, the primary care system or
17 the education system to become knowledgeable about these
18 early warning signs and to look at doing screening and then
19 look at doing referral.

20 It seems to me that we've got to figure out --
21 the collective "we" -- how we can begin to integrate some
22 of these trainings for these other systems in a very
23 effective and efficient way both relative to doing
24 screening, as well as doing referral to other systems, or
25 we're going to totally overburden those systems, which then

1 brings me to the next point.

2 We can do cards. We can do early warning
3 signs. We can do trainings, but I'm not convinced that
4 anybody is actually tracking whether or not any of those
5 strategies are resulting in a significant increase in
6 screening activities within those systems and then
7 resulting in identification of red flags and then referrals
8 for possible intervention. I think that we've got to start
9 paying attention to that if we want these other systems to
10 truly be gatekeepers and to do these early screenings
11 because they can't do everything separate, especially when
12 many of the early warning signs and the screening criteria
13 overlap across these systems. Now, there may be certain
14 specific questions that are separate, but there is much
15 overlap and we've got to figure out how to minimize the
16 workload to those systems.

17 MR. WEBER: One insight of SAMHSA, something
18 that I have witnessed since we put suicide prevention on
19 the matrix and made it a cross-cutting priority. I had one
20 of those profound, earth-shaking meetings. Kathryn Power
21 and Dennis Romero and I sat down together and we said,
22 okay, we have -- don't hold me to this -- I think 36 state
23 incentive grants for substance abuse prevention in states
24 and there are two territories and five tribal
25 organizations. What can we do to integrate what we know

1 about suicide prevention throughout those elaborate systems
2 that we're setting up in all those states and territories?

3 We've actually sat down and started. Richard
4 has sat down with the program staff at the Center for
5 Substance Abuse Prevention and we're actually starting to
6 make some headway into utilizing that system to, again,
7 break down some of those silos.

8 That's also going across back to the Center for
9 Mental health Services. There are some wonderful
10 prevention programs, as well as mental health promotion.
11 How do we utilize that infrastructure that's being set up
12 through some magnificent grant programs to include
13 substance abuse prevention? From my vantage point in the
14 world, which is not on the ground, we tend to all talk
15 about the same risk and protective factors which influence
16 a whole different set of systems that seem to be where the
17 funding is. Now I'll really go out on a limb. If we had
18 an agency for risk and protective factors in the federal
19 government, maybe we'd move something a little bit
20 differently, but that's a whole other conversation.

21 So internally at SAMHSA breaking down those
22 barriers -- and I don't want to leave out CSAT, heaven
23 forbid, some of the incredible work they're doing to ensure
24 that early identification is happening within the treatment
25 system, a treatment improvement protocol which are

1 documents increasingly easier to use, and that will be used
2 to infiltrate the treatment system about what are best
3 practices that can be used in treatment facilities to
4 identify individuals at risk for suicide.

5 On a next level outside of SAMHSA, I am very
6 pleased with the progress we've made to date toward
7 establishing the National Action Alliance to Prevent
8 Suicide. That project is moving forward, and what that
9 project will do, in addition to saying the government is
10 responsible for preventing suicide, it brings in the public
11 sector. It says, okay, public sector, here's your
12 responsibility as well for helping to prevent suicide.

13 DR. CLINE: Mark, I think you mean the private
14 sector. Right?

15 MR. WEBER: I'm sorry. Private sector. I
16 slipped there. The wrong P.

17 So in addition to the public sector, the role
18 and responsibility of the private sector. By doing that,
19 as we look at the potential membership of that Action
20 Alliance, making sure individuals are there from the
21 automobile industry, as well as railroads, who can we have
22 that will have a positive impact on one of these
23 objectives? Because this is much more than the federal
24 government, state or local governments. So, anyway, those
25 are a couple other ways that those barriers are breaking

1 down.

2 One last little comment. Every year we bring a
3 new organization in as part of our suicide prevention
4 awareness activities. I think we have the emergency room
5 physicians on board now that we're starting to work with.
6 A couple of other groups have joined this last year. So
7 one organization at a time. We're bringing them on.

8 I'll talk more with Richard, but what is the
9 impact of that and the evaluation and how many more
10 screenings are happening as a result of these efforts?
11 That would be interesting to know.

12 DR. CLINE: Dr. Gary?

13 DR. GARY: Faye Gary. Thank you very much for
14 such an insightful presentation about a very complex issue
15 which is suicide.

16 I have several observations I'd like to make.

17 Number one, I think we also need to somehow, in
18 our thinking, link suicide prevention or failures in
19 suicide prevention to stigma about mental health. I'd just
20 like to bring that to the table because individuals are so
21 cautious about the stigma of mental illness that treatment
22 is delayed and sometimes that is a fatal outcome.

23 The other issue is, in addition to the public
24 schools, I was wondering if you could expand the
25 gatekeeping concept to include churches and barber shops

1 and beauty shops and the Salvation Army, et cetera where
2 people who may not congregate at the other places that
3 you've targeted will be, or on the street corners.

4 What I'm thinking about is if we look at every
5 level of society, all of whom are vulnerable to suicide and
6 depression, then maybe by having a blanket kind of approach
7 at all levels, that we would inadvertently also address the
8 issue of stigma without specifically saying it but
9 certainly address the issue of stigma. But I think we have
10 to expand it to other populations.

11 And I also would like to include in that the
12 workplace, wherever that might be, the VA hospital, a
13 teaching hospital, the Association of American Bus Drivers,
14 bartenders, or whatever that might be, again so we can have
15 the dialogue and the conversation occurring at every level
16 of the American lived experience. That's number one.

17 Number two, I've worked hotlines, et cetera,
18 and I know how intense it can be. I know sometimes when
19 people call in, there are various levels of intensity or
20 various levels of lethality, which means that the training
21 must be very specific to cover all of the different phases
22 of suicide. We also know that if a person has tried
23 suicide one time, the lethality is higher that the person
24 will try it for a second time.

25 Therefore, my question about the follow-up of

1 those individuals who use the hotline I think is a critical
2 piece, and I'd like to hear some dialogue about that. Do
3 they call again? Do they get referred? Where do they get
4 referred? What is the quality of the care that they
5 receive in the institutions? Because that backs us up to
6 the issue of access to health care, which backs us up to
7 insurance, no insurance, who pays for it, the quality of
8 care, and we could be right back to suicide again if
9 there's not some intervention because if the intervention
10 doesn't occur in a timely fashion, then we have
11 hopelessness and despair that increases, which also means
12 that the possibility of suicide is also enhanced.

13 I'm also thinking that since we have computer
14 systems in place, is there any way that we could track
15 nationwide what happens to people and at the same time
16 preserve their confidentiality so that we really, really
17 can have a sense of the impact of the interventions that
18 are occurring and at the same time save lives and also
19 improve the program?

20 Again, thank you for such an insightful
21 presentation.

22 MS. MARSHALL: Based on the initial rounds of
23 research that were funded by the first SAMHSA grant for
24 hotlines, some of what you're asking is actually already
25 available. We've seen some information about what happens

1 with follow-up calls and whether crisis centers are
2 effective or not and what they do well and what they need a
3 little bit of help with. Actually, if you're interested,
4 the entire June issue of Suicide and Life-Threatening
5 Behavior, which is a professional publication that AAS
6 publishes, was all about the crisis center research and the
7 outcomes of that. A lot of that is available.

8 What we saw, because I was here when the first
9 presentations were made on the outcomes of the research,
10 was very exciting in terms of things that were going very
11 well. Some people were sitting back and going, oh-oh,
12 that's really bad, but in a way I looked at that as an
13 opportunity to say, okay, this is something that's not
14 working well. So what can we do to fix that? Largely
15 under the leadership of the Lifeline Network, the gaps that
16 were found are being plugged and I think being plugged very
17 well.

18 There was information about referrals. There
19 was information about tracking referrals.

20 Quality of care is one of those issues,
21 actually since we were talking about gatekeeper training,
22 that both the SPRC and AAS have taken on, which is to
23 improve the training of mental health professionals who are
24 receiving those referrals because if gatekeeper training is
25 working and more people are being referred for treatment,

1 then you need to be sure that the mental health
2 professionals are the very best they can be. So there are
3 two training programs available in the country right now
4 strictly for mental health professionals, and we are seeing
5 an enormous amount of interest in that, of clinicians
6 wanting to sharpen their skills. So that deals with part
7 of it.

8 If I can just real quickly -- I'm going to horn
9 in on Mark here for just a second -- go to your first
10 question about other places besides public schools. I
11 think we hear a lot about presentations in public schools,
12 and there's a concerted effort to do that. I will tell you
13 that I have done gatekeeper training in just about any
14 venue you can think of. If somebody will ask me in and sit
15 still for an hour, I'll do a gatekeeper training. I have
16 been in Salvation Armies and I have been in churches. I
17 mean, my own church sponsored a suicide prevention evening
18 and had me come in as a speaker.

19 Also, another thing that we're doing -- and
20 this ties in with what Richard was talking about, the
21 warning signs. There actually is a list of warning signs
22 that's sort of been approved by a task force that I think
23 NIH was in on the funding. It was an international group
24 that came together. What they did is they Googled suicide
25 prevention on the Internet and went to thousands of

1 websites that had warning signs listed. No two of them
2 were the same. So in the sort of confusion of how do you
3 prevent suicide and what do you look for, that was even
4 more confusing. So this whole task force came together.
5 Those warning signs are used on the Lifeline cards.

6 Also, this is a project we just launched and
7 it's one of my favorites. We're doing a program called "A
8 Million Voices," and the idea is to raise \$1 million, a
9 dollar at a time, from a million people across the country.
10 The people who donate a dollar or more get a little card
11 that has the warning signs. It has the Lifeline number on
12 it. They give us their names and how much they
13 contributed.

14 All of that money is going to go to survivor
15 services that are provided through AAS. That's been the
16 decision on that, which really excites me. But that is
17 literally on the streets, an on-the-street-corners
18 campaign, where people are going to their churches, going
19 to their workplaces, passing out the cards, taking the
20 contributions, and using it to fund more.

21 It's springing up all over the place. There
22 are fraternities and sororities that have taken it on.
23 There are workplaces that have taken it on. There are
24 entire states that have taken it on. So I think we're
25 beginning to see bit by bit the information getting out in

1 a lot of different ways. Some of them might not look real
2 big, but they're very impactful.

3 DR. CLINE: Just to pause and ask Ms. Holder if
4 she has any questions for the group. Ms. Holder, do you
5 have any questions?

6 (No response.)

7 DR. CLINE: She may not be on the line. Okay.

8 MR. WEBER: Actually, it's interesting. Judy
9 Cushing knows I'm thinking about her. She slipped me up a
10 note here.

11 But one of the things, Faye, to get to your
12 original statement, I think it is all about the stigma. I
13 mean, that's sort of the bottom line. As I again look at
14 experience and draw comparisons, just last week we released
15 the National Survey on Drug Use and Health, and we've seen
16 now a five-year sustained decline in illicit drug use among
17 youth. You have to wonder why is that happening after
18 going through the '90s where I lived through the exact
19 opposite trend. I think it's what you pretty much
20 outlined, community coalitions across the country coming
21 together in the workplace, in the barber shop, in the
22 beauty shop, everywhere they can possibly get out messages
23 and just making that plain statement that drug use and
24 underage drinking is just unacceptable and this community
25 is not going to support it.

1 One of the people who taught me a lot about
2 that is Judy Cushing. That's why I was sitting here
3 thinking about her and then the note comes up from her.

4 So however the suicide prevention community can
5 work to infiltrate all those different places in a systemic
6 way, I think instead of the sad news we heard last week
7 about the increase in rates, you actually end up beginning
8 to break down that stigma so individuals have hope not feel
9 hopeless. If there's hope, then people tend to seek help.
10 Otherwise, they think it's hopeless and there's despair
11 and a downward spiral with that.

12 So anyway, it can be done. I think the
13 substance abuse prevention community has provided an
14 excellent model recently looking at what has happened with
15 tobacco over the years, another example. It just takes
16 time and breaking down that stigma which is a huge barrier
17 in suicide prevention.

18 DR. McKEON: I just wanted to address your
19 final point which had to do with the issue of follow-up,
20 which I think is an extremely important one. What I wanted
21 to mention is that tracking follow-up is an important
22 component across our evaluation efforts for all of our
23 grant programs. It is a major emphasis in the Garrett Lee
24 Smith program where we're looking at what happens after a
25 screening. Do those youth get a referral, and do they not

1 only get a referral, do they actually make it to treatment?

2 Secondly, in the hotlines specifically, the
3 original evaluation research showed that there were not as
4 many successful referrals as we would have liked. So one
5 of the areas that was emphasized in the current round of
6 evaluations taking place of Lifeline activities has been to
7 look at that more carefully to get a better sense of what
8 obstacles exist, what might be best practices. The
9 Lifeline wants to adapt a training called the "Assist
10 Training" specifically for crisis centers and has supported
11 that through the evaluation research and will be expanding
12 that through all of the over 120 crisis centers in the
13 network.

14 Just next week SAMHSA is sponsoring a
15 conference for all of the members of the Lifeline Network
16 in New Orleans. One of the plenaries is about exactly that
17 issue that you raise. It is about follow-up. We're hoping
18 to be able to identify best practices, and we will be
19 hearing some of the first results from the current round of
20 research evaluation that has been funded over the last
21 three years. So it's a very important issue and one that
22 we're looking at very carefully.

23 DR. CLINE: And, Mr. Stark, we'll let you have
24 the last question on this round.

25 MR. STARK: And this was not a question. It

1 was more of a statement, that one of the biggest challenges
2 I think for all of us, not just suicide prevention but in a
3 whole lot of areas, is trying to get appropriate training
4 integrated into our higher education system as we train
5 more physicians and nurses and psychologists and social
6 workers and other kinds of clinical workers. That's a nut
7 we haven't cracked. It's one that I know all of us in
8 multiple fields continue to try to crack.

9 It ties back to something that you said in
10 terms of going on the website and finding out that every
11 website you come to will give you a slightly different set
12 of warning signs or criteria. That's true in evidence-
13 based practices as well. There are multiple websites. You
14 go to those websites. Although there is some commonality
15 with certain interventions that may be on all of the
16 websites, there is no consistency across the board in
17 criteria of defining an evidence-based practice, and
18 there's probably no consistency necessarily in all of the
19 warning signs on suicide, depending upon which site you go
20 to.

21 But I think those are challenges we all face,
22 and we can't do it within a single field. We have to do it
23 across fields in order to have an impact.

24 DR. CLINE: Thank you.

25 Ms. Huff?

1 MS. HUFF: (Inaudible.)

2 DR. CLINE: Well, we're trying to be respectful
3 of the next presentation's time, but please, just jump
4 right in there.

5 MS. HUFF: I've been on this council for four
6 years. I'm about to go off. I have to say this has been
7 the most emotional and heated issue that the council has
8 dealt with. We've had more than one meltdown, haven't we,
9 Kathleen? So it's really wonderful. I just have to say
10 how wonderful it is to have you all here and have this
11 information and to see, after the issue of suicide got on
12 the matrix, how much activity there has been. So I'm
13 grateful for that.

14 My own nephew committed suicide. When I was
15 the Director of the Federation, I had two staff members
16 whose children committed suicide. So the issue is very
17 near and dear to my heart.

18 I guess the question that I would have is, can
19 you tell me how many people in a year's time or a month's
20 time or a week's time use the Lifeline? How many calls?

21 MS. MARSHALL: I don't have the latest
22 statistics, but Richard probably has them right off the top
23 of his head.

24 DR. McKEON: Yes. There are a couple ways
25 measuring it. We try to utilize a conservative criteria,

1 which is not the number of people who dial but the number
2 of calls that are answered. There are over 36,000 calls
3 per month that are answered by the Lifeline. So that's a
4 very significant number.

5 It was one of the reasons that we believed that
6 a partnership with the Veterans Administration would be
7 particularly important because we've learned that one in
8 five suicides in the United States across the life span are
9 by veterans. So by doing an initiative together with the
10 Veterans Administration, we were able to show that we were
11 able to immediately have over 36,000 people per month hear
12 a prompt letting them know that there was a special service
13 for military veterans for suicide prevention. That's why
14 almost from the start there have been about 100 calls a day
15 that have been coming in to this. So there is a
16 significant number that we are reaching.

17 MS. MARSHALL: If I can respond to what you
18 said. I'd like to thank you for all that you've done
19 because SAMHSA has been the federal organization that has
20 supported suicide prevention in this country from back in
21 2001 when the first hotline grant was issued and then the
22 Suicide Prevention Resource Center.

23 My personal view of this is that we absolutely
24 have to have a strong crisis center network available for
25 people who are desperate. The further back we can reach

1 people with information and help and referrals, the better
2 off we are.

3 So I think SAMHSA is going at it from two
4 different ways. The suicide prevention community is going
5 at it from a number of different ways. It takes all of it
6 to build the kind of safety net that we need to build. If
7 you want to put it into perspective -- you've heard the
8 number 32,000 suicides in 2004 -- that's twice as many
9 deaths as deaths in this country from HIV/AIDS, and it's
10 nearly twice as many as homicides. So you have to look at
11 the resources that we're putting into dealing with
12 homicide, dealing with HIV/AIDS, and say if we put those
13 kinds of resources and that kind of interest in preventing
14 suicide, what can those numbers come down to. That's my
15 challenge.

16 DR. CLINE: Well, Karen and Mark and Richard,
17 thank you very much for the presentation. Thank you
18 especially, Karen, for being here today and for sharing
19 such valuable information.

20 (Applause.)

21 DR. CLINE: And I would now like to ask Ms.
22 Beverly Watts Davis and Mr. Fricks as well to move to the
23 front. Ms. Watts Davis is the Senior Advisor to the
24 Administrator, and she will be heading up this next section
25 for us. Welcome. So, Beverly, the floor is yours.

1 After this presentation and questions, we'll
2 take a short break. You're welcome to take a break now as
3 well if you need to do so.

4 MS. DAVIS: Well, first I want to say good
5 morning to you all. It is such a pleasure to see you all
6 again. I have truly had such a pleasure to know all
7 intimately personally, and it's just good to see your faces
8 here as we welcome in our new Director who has truly helped
9 make sure that workforce is on our radar screen.

10 I want to share with you all that to my left is
11 Mr. Fricks who is really going to bring that authentic
12 voice to this discussion.

13 But I want to share with you all today is
14 really very important. In your notebooks under tab G,
15 we've given you all an update on our activities for
16 workforce development. So I won't read those to you all,
17 but I do want to just bring your attention to the very last
18 line on that page that really talks about SAMHSA's
19 workforce development update.

20 It really speaks to how we convened a core
21 competency diffusion model meeting under our workforce
22 development contract. I really wanted to thank Dr. Clark,
23 who is not here. I know he just left. This meeting was
24 really very, very good. It was a meeting that was attended
25 by all three centers' staff, but more importantly, it had

1 practitioners predominantly from mental health and from
2 treatment. What was really important is the fact that they
3 came up with really four recommendations, if we could bring
4 up the slide. But there were four recommendations that
5 they wanted me to share with you all. This was an
6 opportune time since you all were meeting and the issue was
7 workforce development.

8 First off -- and these are not going to be
9 unusual recommendations, but I thought the fact that these
10 came from our practitioners from around the country -- here
11 were the key things that they said. If SAMHSA could do
12 anything to affect workforce development, these would be
13 the kinds of things they would be doing. No surprise that
14 the issue of funding is there.

15 But one of the key things that they talked
16 about in this meeting was the fact that clinical
17 supervision, which is so key for both treatment and mental
18 health, was something that is actually not billable. When
19 we think about the care that has to be given to our clients
20 and the fact that clinical supervision is absolutely
21 necessary to the workforce coming in, they talked about the
22 fact that it is not billable really does hinder overall the
23 clinical supervision being done. And secondly, when
24 organizations have to decide are they going to be making
25 payroll, are they going to be delivering services, are they

1 going to be able to support staff development activities,
2 if they do not have a grant that year, then quite frankly
3 the money for workforce development, particularly clinical
4 supervision, is not there.

5 This really leads to our second point. When
6 they talked about the funding -- I was at the meeting. We
7 talked about it's not just the fact that more money is
8 needed. It's not just about more money and more money and
9 more money. It's quite frankly how money is spent. One of
10 the key things -- you all know this, as I know this from
11 being out in the field -- is that the funding that is less
12 than five years really does contribute to, they said, the
13 destabilization of our field because in organizations,
14 because both at the state level and at the community level,
15 when it comes to workforce development activities, they're
16 not sure if they're going to have a budget the following
17 year. So when they have to decide do I do service, do I do
18 staff development, what's going to be their choice? It's
19 going to be the thing they can bill for, that they are
20 getting funded for.

21 One of the key recommendations is that if the
22 federal government, SAMHSA in particular, could take a look
23 at -- when we're funding, if we were going to be doing
24 workforce development activities, one of the key things we
25 could do is look at how we fund our grants because five- to

1 ten-year funding allows for the base to be stabilized so
2 that they're not afraid to spend some money this year on
3 staff development that they need because they know that
4 they will have funding for next year as opposed to
5 competing year after year after year wondering whether or
6 not they will get their funds in the following year.

7 They also said at the state level that we
8 really should work with the states to really focus in on
9 coming up with a workforce development plan. Vermont was
10 really unique in the news on this in that they actually had
11 a workforce development coordinator. She was sharing with
12 us that this was her state's commitment to that. But many
13 people around the table said, my gosh, none of our
14 organizations actually have a person that's dedicated to
15 workforce development even though it is the most important
16 issue that our field is facing right now.

17 Thirdly, they talked about technology and the
18 fact that the days of being able to move people around to a
19 training here or a training there, with the funding as
20 tight as it is, is just not possible. So we should really
21 look to see how we can utilize our technology to diffuse
22 training and technical assistance to the field.

23 And fourth is that peer-to-peer training really
24 should be supported. The authentic voice of what peers are
25 facing on the ground was the key issue that they were

1 bringing forth, that it's the peers who really understand
2 what has to happen in organizations. It's not just a
3 canned training, but they're able to infuse the kinds of
4 advice that colleagues need in terms of addressing any
5 issue. So I wanted to share these with you.

6 That fourth point really does lead me to our
7 next presenter who is Mr. Larry Fricks. The group really
8 talked about one of their key points as being having the
9 authentic voice being able to be involved in the training
10 sessions around the country, that authentic voice that
11 could begin to answer questions that are not within the
12 canned guide, that are not within the written materials.
13 It's the kind of questions people say, but wait a minute.
14 We know that this is possible, but we all know that we're
15 kind of doing what we need to do to get around this
16 particular issue. Is there anybody else who has dealt with
17 this problem? Having a peer say, yes, this is how you can
18 address this problem is something that they said really
19 does need to be supported.

20 Mr. Fricks, who is here to my left, is the
21 Director of the Appalachian Consulting Group. He is also
22 Vice President of Peer Services for the Depression and
23 Bipolar Support Alliance. You all have his biography in
24 there. But he spent 13 years directing Georgia's Office of
25 Consumer Relations and Recovery in the Division of Mental

1 Health, Developmental Disabilities and Addictive Diseases.

2 One of the key things that I actually know him for is that
3 he is the founder of the Mental Health Consumer Network
4 that has over 3,000 members. He is also the founder of
5 Georgia's Peer Support Institute because what they really
6 do do is support training from peer to peer to peer, again
7 raising that authentic voice forward. He was on the
8 Planning Board for the Surgeon General's Report on Mental
9 Health and is on the board of directors of Mental Health
10 America. He is also on the advisory board for the Carter
11 Center for Mental Health Journalism Fellowships.

12 This is just a little bit about him. He has a
13 journalism degree from the University of Georgia, but most
14 importantly, he has won journalism awards from the
15 Associated Press, the Georgia Press Association, and
16 Gannett Newspapers. He was the recipient of the 1995
17 Clifford Beers Award given by Mental Health America, and he
18 was a recipient of the 2001 award from the American
19 Association for World Health. He is also the recipient of
20 the Recovery Award from the International Association of
21 Psychological Rehabilitation Services.

22 Again, I was so pleased to be able to introduce
23 him because we all know how important recovery support
24 services are and to be able to have our field out there
25 generating issues around this, generating support around

1 this, generating capacity around peer-to-peer recovery is
2 really important. So I want to be able to bring to you the
3 authentic voice of Mr. Larry Fricks.

4 MR. FRICKS: Thanks, Beverly. Thank you all.
5 Thanks, Terry.

6 On August 15th, there was a fairly historic
7 letter that went out from CMS from Dennis Smith. Basically
8 that letter went to all the Medicaid regions, and it
9 acknowledged peer support as an evidence-based practice.
10 It acknowledged that a workforce of trained peers was
11 essential to system transformation, and it actually
12 provided the three guidelines for how states can bill
13 Medicaid for peer support and train and certify that
14 workforce. So that was very important.

15 I want to thank Kathryn and CMHS. Early on
16 they saw the concrete real transformation that comes from
17 those of us that have the lived experience of recovery,
18 gaining skills to help each other self-direct our own
19 recovery. We so appreciate that and the support of the
20 resource kit on how to set all this up.

21 My guess is probably about 3,000 peers have
22 been trained across the country to meet the criteria of
23 what Medicaid is requiring to meet their guidelines. It's
24 really sort of exploding now.

25 Thanks to SAMHSA for funding through NASMHPD,

1 to Bob Glover and INTAC for technical assistance to states
2 that want to start peer programs. For states that didn't
3 get the big multimillion dollar TSIG grants, they provided
4 TA on items that commissioners say were really important.
5 Most commissioners voted peer support. So that TA, Kathryn
6 -- I think we've got 12 states now. They each get \$10,000
7 they can use toward TA. In fact, I was in Alabama Friday.
8 They're one of the first states to respond. You may not
9 know this, but they just put \$1 million in their budget for
10 peer support. They just put \$1 million.

11 MS. DAVIS: Explain what the TSIG is.

12 MR. FRICKS: The TSIG is the state
13 infrastructure grants, the big grants for system
14 transformation. What does SIG stand for again?

15 MS. DAVIS: State Incentive Grant.

16 MR. FRICKS: State Incentive Grant, right. Not
17 all states got those. I guess there are nine that have
18 them. So the states that didn't get them can have access
19 to this technical assistance. It's a contract through
20 NASMHPD and INTAC.

21 This is a quote I love. "Revolutions begin
22 when people who are defined as problems achieve the power
23 to redefine the problem." I think the peer workforce has
24 shaken up the system. I think we're telling you that you
25 may have focused on the wrong things and you may have

1 wasted some money, quite frankly.

2 I just want to give you a little bit of insight
3 into why the peer workforce is so unique and why I think
4 it's exploding across the country. If you go to the center
5 circle there -- you know, I'm in recovery from bipolar
6 illness and I'm also clean and sober 20 years. I manage my
7 illness daily. I've not been hospitalized since the mid-
8 '80s. But if you talk to clinicians, they will tell you
9 what disables you is the symptoms. Now, I do not deny that
10 when I was manic and God was communicating to me and I got
11 on some pretty wild tears, quite frankly, Sherman on his
12 march to Savannah did no less harm than I did on my manic
13 experiences. But I don't deny that the symptoms are huge.
14 The problem is when I got sick in the mid-'80s, that's all
15 they focused on.

16 If you go in and talk to us, we'll tell you
17 that there are really things that disable you. It's the
18 symptoms. It's the stigma, and it's really the self-image,
19 how much we buy into the stigma. All three are what
20 disable us. So we need great clinicians for the symptoms,
21 but the peer workforce is trained to take on the other two.
22 That's the stigma and the negative self-image.

23 I really think a lot of the stigma comes from a
24 belief that our brain is so broken that you could never
25 trust our thought process. I was so very sick and, quite

1 frankly, very, very sick, but if you write us off and don't
2 consider our strengths, then you're sort of doomed to a
3 control model that's based only on our disability and our
4 illness, and you waste so much.

5 So if you get that concept that there are
6 really three things and the peer workforce is focusing on
7 the stigma and the negative self-image -- we have up here
8 five stages in recovery. This comes from Pat Deegan's
9 recovery story from schizophrenia. You all may know Dr.
10 Pat Deegan. She, I think around '94, did the first
11 training on hearing voices, what it's like to hear voices,
12 and try to navigate a mental health system that's locked
13 into itself, as opposed to focusing on what the individual
14 needs.

15 But the five stages. In the first stage,
16 you're overwhelmed by the disabling power of a psychiatric
17 diagnosis. That's what we call impact of diagnosis.

18 The second stage, you've kind of given into it
19 and your life is limited. Those are the folks -- you ask
20 them something about themselves, and they say, well, I have
21 manic depression or bipolar. And you say, well, tell me
22 something about your life. I go to a day program. Well,
23 tell me something else about your life. I take lithium.
24 Actually their life has been redefined by their illness.

25 Then the third stage, a very healthy stage, is

1 when you begin to question the disabling power of a
2 psychiatric diagnosis and you begin to think that change is
3 possible. That's when the peers are trained to bring
4 oxygen to whatever that little flame of hope is. Just as
5 quick as they hear hope, they just bring oxygen to it and
6 build on it and do person-centered planning.

7 The next stage is you're beginning to challenge
8 the psychiatric diagnosis and its disabling power. We call
9 that "commitment to change." Some people need to realize
10 when you challenge, it can be a sign of recovery, not
11 noncompliance. It can actually be a real healthy sign.

12 Then the last stage is that you're moving
13 beyond the disabling power of a psychiatric diagnosis.
14 That's when you need actions for change. If you'll notice,
15 one box is yellow. The other four are not. That's because
16 the first box is the only one that deals with our symptoms.
17 The other boxes have to do with our beliefs, and the peer
18 workforce is trained to change those beliefs.

19 So there are new areas that the peer workforce
20 is moving into. We've just developed curriculum for
21 homeless, peers that want to work in the homeless area that
22 maybe have been homeless themselves. At Emory University,
23 we've developed a new curriculum for aging, and we've just
24 gotten funding to develop a curriculum for young adults 18
25 to 22. We have peer curriculum for trauma.

1 Something hot that's going on, Georgia is an
2 Olmstead state. When we went in and started asking people
3 if they wanted to move to the community, many of them said
4 no. Quite frankly, I think you can become so
5 institutionalized, you're afraid. So the peers were the
6 only ones that could convince them that they could probably
7 have a life. So Georgia has just funded a peer mentoring
8 program. The first pilot was so successful, it's now
9 statewide.

10 The one I want you to take a look at that I
11 think is huge and we are so excited about is the thing
12 called "peer-led health self-management."

13 I think most of you are aware of the October
14 2006 report that came from the medical council of NASMHPD,
15 the association of health commissioners, that people with
16 serious mental illness served by the public mental health
17 system die on an average 25 years earlier than the general
18 population. This was such a big deal that the old
19 newspaper chain I used to work for, Gannett -- Gannett owns
20 USA Today. It was the lead story in USA Today on May 3rd.

21 "Adults with serious mental illness treated in public
22 systems die about 25 years earlier than Americans overall,
23 a gap that's widened since the early '90s when major mental
24 disorders cut life spans by 10 to 15 years."

25 It's interesting. The report says that

1 preventable medical conditions are metabolic disorders,
2 cardiovascular disease, diabetes. Pay attention to
3 metabolic disorders because I'm going to talk a little more
4 about that and how we're training peers to have an impact
5 on that.

6 The report says that preventable risk factors
7 are obesity, smoking -- 44 percent of all cigarettes smoked
8 in America are smoked by people in recovery -- substance
9 abuse, inadequate access to medical care, and some
10 psychiatric medications. This report is huge. I was just
11 at Boston College, and the docs there triage their
12 medications. They're trying to use first the medications
13 that they know don't impact weight gain, cardiovascular,
14 diabetes. So this report is having a big impact. Terry,
15 I'm sure you're aware, as former commissioner, that this is
16 sending ripples through the system.

17 So here's what's happening. Dr. Ben Druss, who
18 is the Rosen Carter Chair of Mental health in the Rollins
19 School of Public Health at Emory University, has gotten a
20 National Institute of Mental Health research grant to study
21 adapting a chronic disease self-management program that
22 Kate Lorig started at Stanford University. It's in 400
23 sites across the world. Basically Lorig believes that
24 peers can change health behavior, or she's proven it better
25 than anyone else, if you do person-centered planning and

1 you pay attention to what it is the individual is willing
2 to start with. So her model has been used in HIV. She had
3 a 30 percent change in self-health behavior, peers leading
4 that, all the chronic diseases, but she never tried it out
5 in our field.

6 So Druss got a grant to adapt that model. So
7 we have hired two peer specialists that went through our
8 training and they're now hired by Emory University. We are
9 adapting that training for peers in recovery from mental
10 illness to help other peers change their health behavior.
11 It's a two-year study. We're the first year into it, and
12 it's going to be pretty remarkable, I can tell you. So we
13 are already training peers on what's killing us and what
14 peers can do to reverse that.

15 Basically the model is proving to adapt well
16 because it results in sustainable change in healthy
17 behaviors and health in persons with a range of chronic
18 conditions, is consistent with efforts to incorporate self-
19 management and peer support to foster recovery for people
20 with severe mental illness, is applicable to populations
21 with multiple risk factors and/or comorbid conditions. So
22 it's really proven out to work well.

23 The other thing that we're doing is we have an
24 eight-week pre/post study starting in 2008 at two peer
25 centers in Georgia and one in Worcester, Massachusetts.

1 Basically, remember what they said about the metabolic
2 factors and how that's contributing to our early death? We
3 have just gotten trained at Harvard Medical School by our
4 staff, by the Benson-Henry Institute for Mind-Body
5 Medicine.

6 How many of you have heard of a cardiologist
7 named Herbert Benson? He was famous in 1975 for a book
8 called "The Relaxation Response." Basically he studied
9 what stress does to the body and the fight or flight
10 response. He determined there was something you could do
11 almost immediately to counter that. Stress is such a
12 killer. I think probably our population is under more
13 stress than most populations because of poverty,
14 hopelessness, discrimination.

15 So basically the relaxation response decreases
16 metabolism, decreases heart rates, decreases blood
17 pressure, decreases breathing, decreases muscle tension
18 and, if practiced regularly, can have lasting effects. So
19 all of our peers going through training are now trained how
20 to use the relaxation response to counter stress.

21 The Benson-Henry Institute also teaches you
22 about cognitive restructuring, how to replace negative
23 thoughts. So we're doing an eight-week study on this and
24 going to look at what it does to the metabolic factors over
25 eight weeks using both the relaxation response and

1 cognitive restructuring.

2 In fact, they just renamed it the Benson-Henry
3 Institute because Henry is John Henry who owns the Boston
4 Red Sox, and he's put \$10 million in. So if you put \$10
5 million in, you get your name on the institute.

6 I think that's my last slide.

7 At any rate, these are exciting times. Just
8 once again, I wanted to thank SAMHSA and CMHS for all your
9 support. The peer workforce has arrived. Medicaid is --
10 Georgia will bill \$10 million this year for peer support.
11 Thanks.

12 DR. CLINE: Thank you, Larry. That's wonderful
13 work and I appreciate not only your work but your vision
14 for the field and for people across our country. So thank
15 you very much.

16 Questions? Ken?

17 MR. STARK: Larry, I appreciate your comments.
18 I was impressed with the whole issue of looking at the use
19 of peer supports and family supports not only around mental
20 health promotion, but also around health promotion in
21 general. With that report about early death, I've been
22 surprised actually -- and maybe it's just being way up
23 there in the Pacific Northwest, but I've been surprised at
24 the lack of activity around that issue because it sure
25 seems to me that particularly on the public sector side,

1 where we're so tied in with mental health and Medicaid,
2 that you could truly do a number of interventions using
3 peer and family supports to help mitigate chronic health
4 care costs in the long term as a prevention strategy.
5 There is clearly an opportunity for linkage here with
6 primary care and mental health that seems to be very slow.

7 And I would be very interested, before I leave,
8 in getting your card because I want to call you and follow
9 up with you and see if I can get you to come to Washington
10 State to talk to some folks.

11 MR. FRICKS: I would love to.

12 A couple things happen here. If you start
13 looking at us holistically, it's going to really do a
14 number on the stigma because you can't see us as our
15 symptoms of schizophrenia. You see us as a person
16 holistically. Not only does it change how you look at us
17 as whole people, it also opens you up to deeper and wider
18 funding pockets. I mean, the Benson-Henry Institute just
19 got \$2.7 million from the CDC. So when you open up to the
20 whole health issue --

21 You know, what Kate Lorig is showing is that
22 the reason a peer changes your health behavior, if you use
23 person-centered planning, is you walk up to somebody and
24 say, you got to lose 50 pounds, you got to quit smoking,
25 and you got to start exercising. You know what you're

1 going to say? Well, you know what? Let me go get a pack
2 of cigarettes and a pizza, and I want to sit down and think
3 about this. But what Kate Lorig's model teaches you is
4 find out what it is, if anything, that person is motivated
5 to start with, walking to the mailbox, and you build on
6 that. She says do not tell somebody quit smoking. Don't
7 do that. So it's based on the same person-centered
8 planning model that we have in mental health.

9 So I'm very excited about this. I think it's
10 going to change the whole -- if you don't start practicing
11 integrated recovery, you're going to miss it. The train is
12 leaving. It's happening right now.

13 DR. CLINE: Dr. Gary?

14 DR. GARY: Thank you very much for a very
15 fascinating kind of presentation.

16 I liked your slides, and if you could share
17 those with the rest of us, your models, et cetera, that's
18 number one.

19 Number two, in the models and in your
20 discussion, I did not hear a lot of focus on work, the
21 significance of work in a person's life. I wondered if you
22 could integrate that general concept of the significance of
23 work. We know that after individuals have the burden of
24 mental illness, it's difficult to find a job, and we know
25 that there are days and days and days and hours and hours

1 and hours when there is no focused activity. For an
2 example, I've had patients who tell me they go to the pool
3 room all day, that kind of thing.

4 I think that's the other piece we have to
5 interrupt and make sure that they have purposeful activity
6 during the day related to one's self-recovery but also to
7 work in some fashion.

8 MR. FRICKS: Yes.

9 DR. GARY: So could you just say how work fits
10 into this model?

11 MR. FRICKS: First of all, I'd like to come
12 over and give you a hug.

13 DR. GARY: Well, come on.

14 (Laughter.)

15 MR. FRICKS: That's been my whole background
16 with my 13 years with the state, and that's because the
17 Georgia consumers every year at their conference voted
18 their top priority and it was employment every year.
19 That's why Georgia was actually the first state to go after
20 a workforce of trained peers is because the consumer
21 movement had made work their top priority.

22 You know what's interesting to me? I helped
23 restore the cemetery of 25,000 patients buried on the
24 grounds of the state hospital in Milledgeville. There's
25 the largest cemetery in the world of people with

1 disabilities. I read the first annual report from the
2 superintendent to the Governor in 1842, and he said to the
3 Governor what's amazing is if the people have something to
4 do, if they're engaged, their symptoms abate. This was in
5 1842 before medications.

6 So really the whole trained peer workforce came
7 out of the Georgia consumers saying we want something
8 meaningful to do. The reason the peer thing is so powerful
9 is, if you look at the Benson-Henry Institute research on
10 resiliency, they'll tell you what causes somebody to be
11 resilient is a social network. Well, that's peer support.

12 It's the relaxation response dealing with stress, having
13 to manage your stress. It's also altruism. So the peers
14 helping peers recovery captures that whole concept and
15 resiliency of altruism. So not only does it help
16 strengthen your recovery, it strengthens my recovery also.

17 So absolutely, having something meaningful to
18 do -- in my own recovery, when I got a chance to write a
19 column for a local newspaper -- they paid me \$25 a column
20 -- it changed my life because I had something meaningful to
21 do.

22 MS. DAVIS: Dr. Clark can really talk about the
23 whole idea of the peer-to-peer support program that SAMHSA
24 does have. One of the key factors, because this came up in
25 the meeting, is they said one of the key things that SAMHSA

1 has done both with Access to Recovery and the Peer-to-Peer
2 Recovery Support Program is it actually supports family
3 activity, social connectedness, the resiliency factors you
4 just spoke about, and more importantly, employment training
5 and things for work. There aren't many grants, unless
6 you're out of the Department of Labor, that really do help
7 support that work.

8 Dr. Clark, you may want to talk about the Peer-
9 to-Peer Recovery Support Program.

10 DR. CLARK: I think Larry Fricks' comments are
11 captured in our recovery community services program and
12 Access to Recovery initiative, both of which recognize that
13 opportunities for work, opportunities for dealing with
14 family obligations like taking care of children, dealing
15 with logistical issues like transportation, all those
16 things are of critical importance, and we've structured
17 that in the substance abuse arena.

18 The issue of stigma is also a major component
19 of that. So people who are able to reintegrate into the
20 larger community not only get the benefit internally but
21 also from the larger community's reconceptualization of
22 that person's problems.

23 DR. CLINE: Any other questions for our
24 panelists? Comments? Ms. Dieter?

25 MS. DIETER: I'd also like to have your models.

1 I don't think we were given those.

2 DR. CLINE: Those were not included. We'll
3 make sure that you have copies of those, all the council
4 members.

5 MS. DIETER: Thank you.

6 What you had to say had a big impact from my
7 experience with my family member, and I'm just really glad
8 you said it and that you're here doing this. Thank you.

9 MR. FRICKS: Thank you.

10 DR. CLINE: So, Larry, I'd like to thank you
11 for being here, and Beverly, thank you for providing the
12 presentation. Ms. Watts Davis and Ms. Power co-chair the
13 workforce development matrix line here at SAMHSA, and
14 Kathryn will be presenting later on some veterans issues.
15 So we divided the labor a little bit here for the council.
16 But Beverly, thank you for the presentation today, and
17 Larry, thank you as well. Thanks.

18 (Applause.)

19 DR. CLINE: We will now take a 15-minute break
20 and resume at 11 o'clock.

21 (Recess.)

22 DR. CLINE: We're going to go ahead and get
23 started. Thank you all very much for rejoining us.

24 To wrap up our morning presentations, we have
25 Larke Huang who is the Senior Advisor to the Administrator.

1 I understand that Larke has presented to this group
2 before, but we may have some members who are not familiar
3 with her. So I have asked Larke to say just a little bit
4 about her background so that all of you will have a sense
5 of who she is.

6 Larke, the floor is yours.

7 DR. HUANG: Thank you, Dr. Cline.

8 Some of you I know from different arenas of my
9 life. Others I'm just meeting. I am the Senior Advisor
10 here on children and families. I work in the Office of the
11 Administrator. I am a clinical psychologist by training
12 and have worked in the field for about 30 years now in a
13 variety of capacities, as a program developer, as a
14 clinician with provider agencies primarily in California,
15 and as a researcher and a program evaluator as well. Prior
16 to coming here -- I've been here for about a year and a
17 half now -- I worked on the President's New Freedom
18 Commission and know Dr. Lehmann from there, and then was
19 asked to come to SAMHSA at the conclusion of that
20 commission. So that's in brief a little bit about me.

21 We're going to talk to you today about one of
22 our youth initiatives, and we're real excited about this
23 cross-agency -- actually it involves 10 different federal
24 agencies to look at challenges and issues for America's
25 youth. The initiative is called -- and I'm sorry it's

1 behind you -- "Helping America's Youth Initiative," often
2 referred to as the HAY initiative.

3 What we're going to do in our time here is we
4 have a brief presentation. I will give you an overview of
5 the initiative. My colleague, Charles Reynolds from the
6 Center for Substance Abuse Prevention, will preview the
7 online community guide, which is one of the products of
8 this initiative. My other colleague, Leah Truitt, who is
9 with Family, Career, and Community Leaders of America, from
10 one of our school-based leadership organizations, will talk
11 to you about the HAY initiative from a youth perspective.
12 And then we'd like to save the bulk of our time looking at
13 some of the challenges and key discussion questions around
14 where we want to go forward with this particular initiative
15 and some new issues that have just arisen around this that
16 we want to share with you.

17 So let me begin by telling you about this
18 initiative. You do have the slides for this in your
19 materials. This is an initiative that comes out of the
20 White House, out of the Office of the First Lady. The
21 focus on this was raising awareness about the challenges
22 facing our youth, primarily adolescents. It was built on
23 the assumptions, which are research-based assumptions, that
24 opportunities to engage with youth, if there's a caring,
25 supportive adult connection for youth with or at-risk of

1 various challenges, whether they're mental health,
2 substance use, educational, gang involvement, that those
3 caring connections can make a difference in the lives and
4 the outcomes for those particular youth.

5 So the theme of this initiative is developing
6 caring connections between youth and adults in multiple
7 domains of their lives, in families, in schools, and in
8 their communities, and then to provide strategies for those
9 youth connections to link with what we know as effective
10 programs in prevention and intervention for youth with or
11 at-risk of mental health, substance use challenges.

12 These are the partnering agencies. There are
13 10 federal agencies that are involved in this particular
14 initiative. This is a federal working partnership. We do
15 meet regularly several times a month on continuing to
16 develop this guide, develop this initiative, do meetings
17 around the country for small groups of states.

18 The key components of this initiative are a
19 website, which is providing information and resources, key
20 data around youth issues and youth challenges. It also
21 provides information on programs that we feel are making an
22 impact in their communities around youth challenges that
23 have been visited by Mrs. Bush and are previewed on those
24 websites.

25 It also includes developing a community guide

1 to helping America's youth. This is an online guide. It's
2 very much built off of the CSAP Strategic Prevention
3 Framework.

4 And then the third component of the initiative
5 is convening HAY regional meetings designated in a
6 particular state, and then community coalitions from the
7 five contiguous states are also invited to come to those
8 meetings.

9 This is the screen shot of the website. It's
10 at www.helpingamericasyouth.gov. On the website, there are
11 facts about America's youth, about different programs
12 serving America's youth. You can see these are the areas
13 in which information is provided around youth and families,
14 youth and mortality issues, birth rates, mental health
15 issues, substance use issues, violence and violence
16 prevention issues.

17 The community guide is an online guide, which
18 we're going to actually demo for you here. The key
19 components of the guide are looking at building community
20 coalitions, strategies for forming and sustaining community
21 partnerships, conducting community assessments, and then
22 selecting program strategies that have empirical data or
23 evidence-based strategies.

24 The various components of building community
25 partnerships, how to go about doing that, again build very

1 much off of the Strategic Prevention Framework that's been
2 developed in our CSAP initiative. Involving youth is
3 critical and how to do that and strategies for doing that,
4 and then making and sustaining those partnerships.

5 The community assessment is a key piece of that
6 guide, how do you go about conducting a community
7 assessment, and what are strategies for doing that.

8 I'm going to turn it over now to Charles
9 Reynolds, who's actually going to go into the online guide
10 so you can see how it works. Charles?

11 MR. REYNOLDS: Thank you. Basically what I'm
12 going to share with you is a couple of functions within the
13 community guide. The first one we're going to share with
14 you is called MapIt. What we wanted to do was to build a
15 utility or a tool that people can easily find out
16 information about what's in their community, the
17 demographic that they're targeting, the federal resources
18 that are currently available. And we wanted to make it so
19 that it was relatively easy for them to go in and start to
20 manipulate this site and get back meaningful information.

21 We built it so that knowing as little as
22 possible about your community, you can start to go in and
23 start to analyze the site. If I can just be bold enough to
24 give you an example, I'm going to type an address in in
25 Cleveland, Ohio. By simply typing in an address, Bing, we

1 come up with your locality. Now we can actually go in and
2 we can identify what federal resources are there. We can
3 focus in on what's available through SAMHSA or through the
4 Department of Health and Human Services, or we can focus in
5 on what's available from the various federal agencies that
6 are partnered with this program.

7 Once the information pops up, the person can
8 easily identify who are the grantees funding their program,
9 where they're located, and what type of program it is.

10 In addition to that, there are several reports
11 they can generate from the system. They can generate a
12 report which gives them the demographic characteristics of
13 the youth living within the area that they're viewing. It
14 also gives them a detailed demographic report that tells
15 not only the youth characteristics but the household
16 characteristics, the family characteristics, income, and
17 other key demographic characteristics for that site that
18 they're looking at. They're going to also identify a quick
19 report which gives them a detailed description of all the
20 federal grants that are not only in that immediate area,
21 but are awarded not only to that locality that they're
22 looking at, but also awarded to the county or to the state.

23 So they can identify rapidly what resources are currently
24 there. Now, that's one function of the community guide.

25 Another function is that we realize that we

1 don't know everything. So we built in a capability with
2 that. They can actually go in and enter their own
3 information. For example, if they know that there are Boys
4 and Girls Clubs that are partners with their program and
5 they want to actually display those partnerships on the
6 map, the tool will allow them to plug in a file which has
7 all this information and all this information now will be
8 populated on the map.

9 To give you a brief example, they can create
10 their own inventory we call it. This is a constantly
11 changing and migrating site. So what I'm showing you today
12 will not be there next week because we're constantly
13 enhancing the site. But what you'll be able to do is click
14 on a program, identify who the program is, the address, the
15 key contacts, what service they offer, and actually view
16 that on the map.

17 As I mentioned, several agencies are working
18 together. SAMHSA has taken the lead role in the spatial
19 analysis part. This part was developed by OJJDP, but we
20 are now working together to make them all look alike. So
21 you can now see that all these programs -- and I can just
22 click on any program here on this map, and it will tell me
23 detailed information about who the program is and where
24 it's located.

25 The last functionality of the tool I want to

1 share with you is something called our program tool, and
2 basically what it is is an inventory of effective programs
3 that the partner agencies have agreed and scored and
4 ranked. It gives you the ability that if you see an
5 effective program, you can select by risk factor,
6 protective factor, and go out and find a program that you
7 would like to replicate in your community or find something
8 that has already been proven to be successful. We ranked
9 them into three categories real quick and without spending
10 a lot of time on it: those that have been scientifically
11 proven, somewhat scientifically proven to be successful,
12 and others that have a strong theoretical base.

13 So you have your choice of types of programs
14 you can actually go in and pick from to replicate in your
15 community. And by pulling up an inventory of all the
16 programs, you can then go in and find out more detailed
17 information about the program, what the program is, what's
18 its target audience, the rating level, evaluation methods,
19 the outcomes, risk factors, and most importantly I think,
20 who to contact to replicate this program in your community.

21 Back to you, Larke.

22 DR. HUANG: This is really a whirlwind tour
23 through this initiative. So I hope that we haven't lost
24 you. The idea behind this is how can we better coordinate
25 across our various federal agencies the youth resources

1 available in any particular community by providing a tool
2 where communities can designate a particular mapped area by
3 ZIP Code or they can draw their geographic map. They can
4 then determine from the 10 federal agencies what kind of
5 grant funding exists in their particular area.

6 So, for example, I heard a little bit of the
7 last part of the previous presentation. We're very
8 interested, as we look at sort of our youth in transition
9 focus here at SAMHSA, what are the employment opportunities
10 there. So for this MapIt piece, you can actually go on.
11 You can pull down the Department of Labor and look at all
12 their One Stop Centers for supported employment for youth.

13 I think there are 3,500 of those. So we don't often work
14 directly with those at SAMHSA, but by partnering with other
15 agencies, we can see what their resources are in the
16 communities where we also have our programs or our grants.
17 So the idea is really looking at how we can share
18 information about our funding, about our grant programs,
19 and also the different data sets that we have in any
20 particular community.

21 Another piece that is on there is that
22 communities can get access to some of the demographics in
23 their community. They can go here and again define their
24 community and look at demographics by age, developmental
25 level, by race/ethnicity, by school performance, and pull

1 this all together so they can have an in-depth picture of
2 what's going on in their community and then be able to
3 identify what the key challenges are and then select
4 through the program tool the database of empirically
5 supported interventions to match up with their needs so
6 that it's an informed selection of interventions.

7 For example, some of the data that's available
8 or that we also share through the regional meetings is some
9 of our national and state data that we collect around
10 substance use and major depressive episodes in our National
11 Survey on Drug Use and Health. They can see it in terms of
12 the national levels and rates and percentages as well as
13 state, and then we also provide this by substate
14 disaggregation as well.

15 Again, we look at some of our data in terms of
16 alcohol use and binge drinking. We can also break this
17 down by state and substate data. Major depressive
18 episodes. I pulled one out here. That just also looks at
19 our data by race and ethnicity. Again, we can look at it
20 by state as well. So this is some of the data that we put
21 on there. Other agencies have their own databases also
22 accessible through this website.

23 I want to turn it over now to Leah Truitt.
24 Part of what we do is have these regional meetings, and we
25 have different communities, different grant programs,

1 different youth organizations participate in those
2 meetings. Leah Truitt and her director, Bana Yahnke,
3 participated in one of our HAY regional meetings. So I'm
4 going to turn it over to her now.

5 MS. TRUITT: Thank you so much for having me
6 here this morning. I'm Leah Truitt and I'm the national
7 Vice President of Community Service for Family, Career, and
8 Community Leaders of America. I'm a senior in high school
9 this year. I live in Galax, Virginia, which is in
10 southwest Virginia. I'm one of 10 national officers
11 elected over the summer at our national leadership meeting
12 in Anaheim, California for FCCLA.

13 Just a little overview of what FCCLA is. It's
14 a career and technical student organization, and it's based
15 in family and consumer sciences classes. So when students
16 take these classes, they're able to join FCCLA and be part
17 of this organization.

18 Family and consumer sciences classes teach
19 skills for life, for example, financial planning,
20 leadership skills, traffic safety, violence prevention for
21 youth, just various skills that are actually needed to
22 apply in real life and on the job.

23 So as you can see on the screen, this is our
24 mission statement. FCCLA involves more than 225,000
25 students across the country, and like I said, our 10

1 national officers were from different states all across the
2 country. We also have members in Puerto Rico, the Virgin
3 Islands, and Washington, D.C.

4 What makes FCCLA unique from other
5 organizations is it's the only in-student organization
6 where the family is its central focus. That's important to
7 FCCLA because we realize how important the family structure
8 is, and by improving the structure of the family as the
9 basic unit of society, you really have the ability to make
10 a change and be out there and hopefully change the lives of
11 youth for tomorrow.

12 I attended the FCCLA Helping America's Youth
13 Conference in Nashville back in April, and I was there as a
14 representative for FCCLA and the National Organizations for
15 Youth Safety. It was an amazing experience. I learned so
16 much about what Helping America's Youth is and how FCCLA
17 can be a part of that and how we can use the HAY resources
18 in our chapters and for our members across the country.

19 Some things that we have in common with Helping
20 America's Youth are we focus on preparing students to be
21 strong family leaders. Like I said, that's our central
22 focus, the family. One of Helping America's Youth's
23 central focuses is coming at the family level and helping
24 kids from the start, from the family, whether that's
25 preschool age or college age.

1 Also, FCCLA programs and Helping America's
2 Youth programs encourage healthy decision-making for teens.

3 This may include healthy eating or making good decisions
4 about drugs and alcohol use and things such as that.

5 One thing we focus on is preparing members for
6 a career after high school, and workplace readiness skills
7 are a big one, having students in the job and learning
8 about having a job in FCCLA. I know we have competitive
9 events that also are geared toward that. We have one
10 called Career Investigation where students are able to take
11 what they really want to do and develop a plan, come up
12 with a goal, carry it out, and then evaluate it for what
13 they want to do for their future.

14 We also provide opportunities for leadership
15 development, and we have meetings across the nation. We
16 get students together to be able to make a difference in
17 their communities. By being a national officer, I got the
18 chance to go to the Helping America's Youth Conference and
19 other conferences like that where I really could gain the
20 leadership skills to be able to go out after I graduate
21 high school.

22 We also train members to recognize, report, and
23 reduce youth violence. This has become a major focus of
24 FCCLA since the past two years when school violence has
25 really become an issue. I live about 30 or 45 minutes from

1 Virginia Tech, so I know in my town and in my community
2 what FCCLA has done to help train members to have the
3 skills to go in and make a difference with youth violence
4 in their communities. So we provide trainings throughout
5 the nation where students can go in. They learn about
6 violence. They learn the statistics about violence and how
7 they can make a difference and actually be able to see a
8 change to the future in youth violence and school violence.

9 Helping America's Youth has been vital to this because the
10 statistics on the web page are a fantastic resource for
11 FCCLA members because they're able to go in and get those
12 very reliable statistics and facts and information to be
13 able to put towards our programs.

14 Another really big focus we have are developing
15 skills for life, not just skills that you're going to need
16 for specific jobs or specific career goals, but just being
17 able to survive as a leader in today's world. So planning,
18 goal-setting, problem-solving, decision-making, and
19 interpersonal communication are all important to FCCLA.
20 That's also a goal of Helping America's Youth, getting
21 students who may not have had a great background up and
22 running and learning the skills to succeed in life.

23 We've been promoting Helping America's Youth
24 since we attended the meetings in April. In our STOP the
25 Violence, which is what I was telling you about with the

1 youth violence and the school violence, we just came out
2 with a new publication tool kit, and we included the
3 website link for Helping America's Youth in this. So
4 chapters, when they begin to start their STOP the Violence
5 projects, can actually go onto the Helping America's Youth
6 web page and take advantage of those resources as well.

7 We also publish information about Helping
8 America's Youth in the national magazine, Teen Times. I
9 have a copy of that right here. This is our national
10 magazine and it goes out to all of our 225,000 members. It
11 comes out four times a year. On the cover here, these are
12 the national officers for this year. We have a few of
13 these packets back there on the back table if you would
14 like to pick some of those up. But we're going to include
15 that in our upcoming issue about what Helping America's
16 Youth is and how our chapters can take advantage of what's
17 available on the Helping America's Youth web page.

18 We also inform chapter, state, and national
19 officers about the HAY programs at the Ultimate State
20 Officer Academy. This is where our state officers from
21 across the country come together and meet to discuss
22 leadership skills and the future of FCCLA. So when we
23 incorporate Helping America's Youth here, we can introduce
24 it to the state officers who can take it back to their
25 chapters and their students. So it really disperses across

1 the country what the potential of Helping America's Youth
2 can do for our students.

3 We also are going to teach them how to use the
4 HAY materials at our cluster meetings. These are meetings
5 a lot of times that new FCCLA members can attend. So when
6 they begin planning their chapter projects for the year and
7 they're really excited about what they're going to do, they
8 can utilize the Helping America's Youth materials to assist
9 them with that.

10 Some of the ways that Helping America's Youth
11 has helped FCCLA chapters already is chapters use those
12 statistics from the website to plan their projects, to
13 evaluate their projects, and see how they can make a
14 difference. On the community guide, I know there's a lot
15 of information about how to form partnerships with other
16 organizations. A lot of times this is hard for youth
17 because being a youth and partnering with adult
18 organizations can sometimes be a little threatening, but
19 with the steps on the Helping America's Youth website,
20 we're able to make that easy and simple. We can also find
21 those programs. I know like we just demonstrated on the
22 website you can use the map and put in your specific
23 location and find lots of other organizations that are
24 planning to do the same things that you want to do that can
25 possibly be a connection to make. With these connections,

1 you can just plan bigger and better and more effective
2 projects.

3 We had members attend the Nashville training.
4 We had three national officers and myself last year at the
5 Nashville training, and we had state officers at the
6 Minneapolis Helping America's Youth training. So we're
7 really getting the word out about Helping America's Youth
8 to our state and national officers to, hopefully, be able
9 to take that back and really make the impact on youth and
10 what Helping America's Youth can do for our students.

11 So thank you so much for having me here today.

12 If you have any questions about FCCLA and about what we're
13 doing with Helping America's Youth, just let me know and
14 I'll be glad to answer them.

15 DR. CLINE: Thank you very much for being here,
16 and we appreciate the youth presence and voice here at the
17 table. So thank you, Leah.

18 Larke, I will turn it back over to you to
19 facilitate our questions and discussion.

20 DR. HUANG: Okay. Thanks, Leah.

21 I wanted to tell you about breaking news around
22 there, so a new development that's just emerged after we
23 actually submitted questions for you to consider on this.
24 The partners in this initiative are looking at how do we
25 sustain this effort, how do we grow it beyond just the HAY

1 initiative.

2 One of the proposals that is under
3 consideration right now is how can we develop a website
4 portal that is for youth. In other words, across all of
5 these agencies, beyond just even the HAY and the focus on
6 the HAY, what would be involved and what would be the kind
7 of information that would be useful to youth, families,
8 communities, states if there were a one-stop shop portal
9 which pulls together all federal agency information
10 regarding youth? And what would you like to see on that
11 from your various perspectives? What would you want to see
12 on such a portal?

13 This is just in discussion this past week, and
14 so I mentioned that I would be presenting this at the
15 SAMHSA Council and that it would be very useful to get
16 feedback from each of your perspectives, and if there were
17 such an e-government youth portal developed, what kinds of
18 information, what kinds of strategies, what kinds of
19 development would you like to see on such a portal? That's
20 actually the question I'd like to lead with, superseding
21 the previous questions we had submitted to Toian earlier.

22 If you have any questions, we know we've really
23 flown through this. We haven't connected all the dots on
24 what this initiative is. But if you have questions about
25 the initiative or about this concept of a youth portal.

1 DR. CLINE: Ms. Sullivan?

2 MS. SULLIVAN: Thank you very much for your
3 presentation.

4 The youth is there. They're on MySpace.
5 They're on all the other websites. Is it possible that we
6 can just link all this information by buying advertising
7 space or in some way to go where they are?

8 DR. HUANG: Well, that's an interesting idea.
9 I just heard, coming in today, a discussion on NPR about
10 MySpace and Facebook and how those are important social
11 networking sites, but there are concerns about how to best
12 monitor those sites and how to bring the parent generation
13 up to speed on both the pros and cons of those sites. So
14 it's a possibility.

15 I don't know if it's a government site, we can
16 link to those sites because of some of the concerns or
17 assets and liabilities around those sites, but we can
18 certainly take it back to the committee. I think those are
19 important social networking efforts, and how we could
20 capitalize on them would be useful to think about.

21 Did you have specifics in mind around that?

22 MS. SULLIVAN: Well, I know what you're
23 referring to, that one out of five are predators or one out
24 of five kids are hit by predators.

25 DR. HUANG: Right. They're registered on

1 MySpace.

2 MS. SULLIVAN: Doesn't it even prove more that
3 if that link for help there, even for predators -- I mean,
4 if there is a link site and you can do it on a main page,
5 not on the subset pages so that you create your MySpace.
6 If it's good enough for major advertisers in this country,
7 I think it's fine. If that's an ethical discussion, I
8 think it should go to the forefront because that's where
9 these kids are. If you're going to link internet or get on
10 the front page of AOL, we might have to pay for
11 advertising. I don't know what budget that would come
12 from, Kathryn.

13 That's my idea. I don't think we should back
14 away because there's controversy. It's been out there for
15 four years. The media just picked it up. Everyone knows
16 about it.

17 And by the way, I contacted a Secret Service
18 agent about it, and he said, well, it looked fine to me
19 because that's where even he looked at it, and he thought
20 it was fine for his kid. So let's not look at the down
21 side of it. That's the audience we care about. Those are
22 the at-risk kids.

23 DR. CLINE: Ms. Dieter, did you have a
24 question, comment?

25 MS. DIETER: Well, it's just in the same vein,

1 and I appreciate all this work. It's quite amazing in this
2 period of time you've been able to put all this together,
3 get all this information. But I am glad to hear that
4 you're trying to now address how to bring the appropriate
5 elements of this information to the youth that are to be
6 the target of this. That's my concern. The website, as it
7 is -- I'm not sure exactly who your target user is, whether
8 it is a --

9 MS. SULLIVAN: Provider?

10 MS. DIETER: Providers. I would assume it's
11 sort of providers or community organizers in that capacity.
12 So to develop something, now that you do have the
13 information, which is amazing, that catches kids'
14 attention, is easy to use -- I'm looking for substance
15 abuse. Boom. It's up there. Whether you have to use
16 advertising to get them to a specific site, you know, you
17 can have an ad on TV. SAMHSA has had ads on TV that direct
18 them to that.

19 I'm really glad you're looking at that. I'm
20 totally in favor of that. I think they're the most
21 important element, you know, to let them be able to access
22 it. I think Kathleen's idea is really great. Where are
23 they going to be? Where can they see this information?

24 DR. HUANG: Our target population for it is
25 broad right now, and as we think about a youth portal, how

1 it needs to be organized for youth users, parent users,
2 caregivers, providers, policy makers, we want it to be sort
3 of a multi-purpose, multi-stakeholder useful portal of
4 federal information. But I think you're right in terms of
5 really highlighting how do we make it appealing so that
6 youth will use it and return to it and find useful
7 resources there.

8 MS. DIETER: Right, youth or parents. I mean,
9 I don't know whether you can do it all on one website.
10 Maybe you can. Right now I think if a young person in
11 trouble flipped on this website, it would be just
12 overwhelming to find a resource. I mean, it's within there
13 somewhere, but there's a lot to go through. So I don't
14 think it's at this point particularly user-friendly on
15 this.

16 MS. SULLIVAN: Can I chime in on this? Have
17 you ever one to AOL's City Guide?

18 DR. HUANG: No.

19 MS. SULLIVAN: Well, there it is. AOL's City
20 Guide is the first thing to come up with this. AOL's City
21 Guide will link all your city resources. So you can use
22 them and they can subset you for a city. You just type in
23 your ZIP Code and you get every restaurant in the
24 neighborhood. So I think you could maybe adjunct to them.
25 I think that would be a wonderful service. If you

1 approached AOL, I think they'd be thrilled. That would be
2 a wonderful partnership.

3 DR. HUANG: Can we quote you on that?

4 (Laughter.)

5 MS. SULLIVAN: I do think they would be
6 thrilled because instead of just selling stuff and
7 merchandising and movies, they'd have something
8 constructive on there and good press for them as well.

9 DR. HUANG: A great idea. Okay, thank you.

10 DR. CLINE: Ken?

11 MR. STARK: My question is to Leah. With the
12 FCCLA, is there a chapter in Washington state, or are you
13 aware of members in Washington State?

14 MS. TRUITT: Yes, we do have members in
15 Washington State. We've actually had national officers
16 from Washington, and we actually have chapters in all 50
17 states, D.C., Puerto Rico, and the Virgin Islands. It's
18 just a matter of finding the schools that have them and, if
19 they don't, starting a chapter there.

20 MR. STARK: Where can I get the list of folks
21 from Washington State?

22 MS. TRUITT: Well, you can talk to Bana Yahnke
23 back there. She works for national staff. So you can get
24 all of that information from her and maybe get in
25 communication with some of their state officers to find out

1 about specific schools and information.

2 MR. STARK: Thank you.

3 MS. TRUITT: Thank you for asking.

4 DR. CLINE: Barbara? Then Dr. Gary.

5 MS. HUFF: Just one observation actually
6 because I love everybody's comments. I think you
7 absolutely have to go where kids are. Kids have to tell
8 you where they go. So I think asking you all would
9 probably be the first thing I'd do, is say where would this
10 be best placed so that all kids can find it.

11 But just the one observation that I made, Mr.
12 Reynolds, when you had all of that up there and you were
13 going to Cleveland, Ohio, I was concerned when you got to
14 the federal government agencies because when you clicked on
15 that, there was HRSA, SAMHSA, CDC. Who would know who
16 those are? But some of us sitting here around this table
17 might. I happen to know who they are. Could I just make
18 the recommendation that we don't do that, that we spell out
19 all that stuff?

20 MR. REYNOLDS: Most definitely.

21 MS. HUFF: You know where I'm talking about.
22 Okay, thanks.

23 DR. CLINE: Dr. Gary?

24 DR. GARY: Thank you very much. Fascinating.
25 I'd also just like to say to Leah you certainly are an

1 excellent example of your organization. You're very
2 articulate, very insightful, and it's a pleasure to have
3 you here with us.

4 My question is to Dr. Reynolds. You said that
5 the programs that are funded are listed in two separate
6 categories, that is, those that have been proven to be
7 capable of meeting their targets or meeting their specific
8 aims and are found to have efficacy. The other group is
9 comprised of those programs that have a theoretical
10 grounding. I didn't understand that very well. Do you
11 have a choice between one or the other, or can I assume
12 that if a program reaches its level of efficacy, it's also
13 theoretically grounded?

14 MR. REYNOLDS: You do have a choice between one
15 or the other. Really, it was just a score for the program.
16 Because the programs came from various federal agencies,
17 we tried to come up with a common way of ranking them. So
18 there are really three scores: ones scientifically proven;
19 ones somewhat scientifically proven; and ones theoretically
20 proven. This a short description of them. We can get you
21 more detail and all this information.

22 DR. CLINE: In some ways, it's almost like
23 using the terminology of evidence-based practices and
24 promising practices and best practices. You're just using
25 a different kind of ranking for some of those, it sounds

1 like.

2 DR. HUANG: Can I chime in here? There's a
3 ranking of 1 to 3. These were really pulling together
4 programs that were identified using different levels of
5 evidence across federal agencies. So we pulled programs in
6 from SAMHSA, from OJJDP, and the highest level were the
7 randomized, controlled trials. The second level were
8 quasi-experimental. The third were promising pre/post
9 evaluation. So that's how they're organized.

10 DR. CLINE: Larke, just to do a little time
11 check with you, we have up to 15 minutes. You had several
12 questions. Our council members have, of course, already
13 started to delve into some of your other questions here
14 just in their questions of you and their comments. If
15 there are particular points you want to hit on, I'm just
16 suggesting that you identify those with those additional
17 questions.

18 DR. HUANG: I think the most pressing question
19 -- I guess there were two. We have tried to develop this
20 with input from communities, but it's primarily been the
21 federal agencies meeting together. At SAMHSA, we had a
22 small contract to do some focus groups, but I feel like we
23 need to go further out to external stakeholders who might
24 find this useful. So I'm really interested in what other
25 ideas you have. What would you want us to take back to the

1 working group on what you would want on a youth portal?

2 Now, it's not just for youth users, but any youth-related
3 information. Or other resources or other strategies.

4 There's a precedent for this particular
5 government effort in disabilityinfo.gov, which is again a
6 cross-agency -- a lot of information around disability,
7 whether it's from the Social Security Administration or
8 Labor or us. But what would you see are the sort of
9 critical pockets of information that would be relevant for
10 furthering policy or programming or funding or strategies
11 for intervention around youth for a wide range of
12 stakeholders? We really want to outreach to the public
13 that includes a broad variety, whether it's policymakers,
14 legislators, whether it's youth and their families.

15 And the second thing is how would you suggest
16 we get better uptake of this particular website and of this
17 HAY strategy planning? Those are probably the most
18 pressing questions right now.

19 DR. CLINE: Ms. Sullivan?

20 MS. SULLIVAN: Did you say you want us to send
21 you this information or tell you right now?

22 DR. HUANG: If you can tell us now, if you can
23 send it in the next couple weeks, that would be great.

24 MS. SULLIVAN: But I mean, it goes to the
25 concept of a kid should find it on something that's

1 accessible, type in a ZIP Code, and up pops anything from
2 federal resources, state resources, Boys and Girls Clubs,
3 church resources as well. I would bring those into it so
4 it's a more complete agenda, not unlike a restaurant
5 listing. Do you know what I mean? If you have problems,
6 contact, and then underneath, you write, if you're
7 depressed, if you feel this -- kind of line under every one
8 of these providers or whatever you want to call them,
9 church groups. But you know, they just go to a list, just
10 a page with everybody's names on it, and they choose.

11 But the key is getting to the kids and finding
12 out -- you know, so the kids can decide on their own. I
13 know the girl down the street committed suicide four months
14 ago, and she spent her entire time -- 15 years old -- on
15 MySpace and no one else got her help. But she was there,
16 an opportunity, and that life, I think, could have been
17 saved.

18 DR. CLINE: Ms. Dieter?

19 MS. DIETER: Yes, and I mean, I wouldn't have
20 it too long a list or this format. It needs to be topical
21 to what their concern is, I mean, depression, drugs, issues
22 where they need more support. It needs to be topical so
23 they can see it right away. You don't say the such and
24 such resource center until they get there. If somebody is
25 in a hurry -- younger people are less patient perhaps than

1 older people. Maybe not. But you want to get to the
2 subject area. Give them something right away and the phone
3 number, the youth center at such and such, the person that
4 they can call.

5 I hate websites where they tell you the
6 organization but you have no idea how to reach them. You
7 don't know where they are. You don't know what the phone
8 number is. You don't know a person or anything. It's
9 crazy. It has to be pretty immediate, I would think.

10 Obviously, it's a little bit hard because you
11 have several targets with the development of all this
12 information. It could be community members, a parent group
13 who's thinking about issues that have occurred in their
14 community often resulting from something like a death or
15 accident. Then they say, now, wait a minute, we're going
16 to try to do something, you know, like Parent Corps or
17 something like that. So they may be looking at it. What
18 do we have existing now? See what we have and then work
19 within that. It could be just parents who are throwing up
20 their hands. I know my child is having trouble. I don't
21 know where to go. Or the kids themselves.

22 So how do you do that? Do you have different
23 websites with a catchy name for each one, or is it all
24 under one? Do you immediately tell the website whether
25 you're a young person or a parent? I think you really have

1 to think through that because you've got the information.
2 So that's probably the hard part. Then it's how to make
3 it --

4 DR. HUANG: You're right. We have the
5 information, and we're also working with nine other federal
6 agencies who sort of want to make sure their audiences and
7 their issues -- and how do we really organize it in a very
8 collaborative way.

9 From the way we're thinking about it here, we'd
10 also like to look at it sort of in the context of a public
11 health approach where we have promotion information there,
12 we have prevention, intervention, treatment, and recovery
13 services and supports. But that's our framework.

14 We're trying to also work with these other
15 agencies who might have slightly different organizing
16 frameworks. So that's part of our challenge, to see how
17 can we have a one-stop entry portal that really is going to
18 pull together all of this information.

19 DR. CLINE: We're going to go to Mr. Stark, Ms.
20 Sullivan, Dr. Gary, and then Ms. Huff.

21 MS. DIETER: I mean, I'll just say one tiny
22 thing at the end. I mean, there are some websites. Like
23 I'm thinking of Blue Cross you go on. Are you a provider
24 or a member? Are you a youth or this? Boom. Then you're
25 going.

1 MR. STARK: Mine was kind of related to -- I'm
2 thinking about if I were a youth and I went on the
3 website --

4 MS. SULLIVAN: You once were.

5 MR. STARK: Yes, a long, long time ago. Maybe
6 in my reincarnation I'll do it again.

7 I'd probably want to go on that website, once I
8 separate issues related to crises. I'm not looking for
9 help at this point or I don't have a friend who is looking
10 for help. Maybe I'm a student and I'm looking at doing at
11 term paper. Maybe I'm a student and I'm looking at wanting
12 to do an internship or get a paid job. Is this website
13 going to be able to help with those kinds of activities as
14 a youth going onto it trying to figure out ways of how they
15 can get engaged in the world today?

16 It may also be a youth who wants to get
17 involved in advisory groups for these various federal
18 agencies or their subcontractors. Are there organizations
19 in the local area where I can get involved in around mental
20 health or alcohol/drugs or homelessness or suicide
21 prevention?

22 Then I think about it from the agency
23 perspective. I think about Washington State. There may be
24 state agencies. Well, there are state agencies and there
25 are providers and substate agencies like county governments

1 or in our state regional support networks who might be
2 looking for youth who are interested in participating in
3 advisory groups, various kinds of coalitions or other
4 groups that can give input into their system. Will this
5 website be able to be useful for that?

6 I'm a mental health transformation project guy.
7 I go on this website. I'm looking for some youth in
8 eastern Washington, specifically maybe Spokane County, who
9 might be interested and available to participate in some
10 community forums on a particular topic.

11 The key to me is being able to find contact
12 information in there. If I'm looking for this and the
13 website gives me some ideas, then is there a name and a
14 phone number or an email address where I can contact
15 somebody to do that follow-up?

16 MS. SULLIVAN: A couple of things. Charles, I
17 think you know kids have a max of three clicks, I believe
18 is what the internet study is. Well, there it tells you
19 something. So we have a three-click maximum here. All
20 right? Let's start with that.

21 MR. STARK: All the adults are getting less
22 than that.

23 MS. SULLIVAN: One thing when we're talking
24 about other websites, I think someone from the private
25 sector who understands kids' web habits should be consulted

1 on the kids themselves and what they use. For instance,
2 TMZ.com. I just thought of one -- is one that, my heavens
3 -- they've gone to a syndication tonight on television. So
4 there's a site where you get the latest news on Paris and
5 Lindsay. What better place to put something on substance
6 abuse?

7 There's another website that I found during the
8 Virginia Tech -- I can't even say the word.

9 MR. STARK: Tragedy.

10 MS. SULLIVAN: Yes, tragedy. I was going to
11 say killings.

12 During Virginia Tech, I found, from listening
13 to television, the number one web hit was a college page.
14 There is a website that college kids go to and share
15 information across the board, and then from there they spin
16 off into chat rooms.

17 So if we contract someone who understands where
18 the kids are, where the priorities are, then you could
19 avoid maybe the MySpace problem. At the moment, I
20 wouldn't. Remember, cops go where criminals are, and we
21 have no problem with that. Right? We have no problem.
22 The cops go where criminals are. I can't stress that
23 enough.

24 One other thing. Because of searches -- Google
25 keeps every search that you have for your lifetime. AOL

1 keeps it for a month. I think that the confidentiality
2 factor among kids is very, very high. They don't want it
3 to be traced. They've already looked at certain providers.

4 I think they would be very attuned to going to a site
5 knowing that it could be traced on their computer they went
6 to a site. So you may have to do secure information.
7 Right? More along the lines of a computerized HIPAA,
8 something like that.

9 Thank you very much.

10 DR. CLINE: Thank you.

11 Dr. Gary?

12 DR. GARY: Thank you very much.

13 Just to follow up on what Ken and Kathleen have
14 said, if you're talking about a portal and three clicks are
15 the max, maybe you might consider building in a hotline
16 click as well so that if a person -- you never know the
17 intensity of the desperation for the knowledge or for the
18 help. So I think if we have a hotline click and have
19 somebody there who can follow through and make sure that
20 the person gets what he or she needs, I think it would add
21 robustness to the website and also help to improve the
22 website over time.

23 The other comment I'd like to make is that I
24 would like for us to give some thought to the population of
25 children who may not go to the website as their first point

1 of defense. I think those are millions of children who are
2 very poor, who are very marginalized, who are very
3 disenfranchised. So I would ask the question, where do
4 troubled children go who are resourceless, no parents to
5 help, afraid to talk with the teachers, burdened with
6 stigma, no money, no telephone, et cetera? Where would
7 these children go and how could we access them so that they
8 can know that these resources are available to them?

9 I think the information is excellent, but
10 that's the population, the unserved and the underserved,
11 that I do not think will have immediate access to this
12 very, very wonderful program. So I think that that's
13 another little task force group session, meeting, focus
14 groups, or whatever to flush that out because I think
15 access is still a problem here.

16 The other is -- and I think it's embedded in
17 your presentation, but I think I would like to see it more
18 explicit -- what happens to children who live in families
19 and communities where violence is the expected
20 socialization behavior and the method of conflict
21 resolution?

22 MS. SULLIVAN: (Inaudible.)

23 DR. GARY: I'm not connecting.

24 MS. SULLIVAN: What I meant is what do they
25 buy. When you talk about these kids, what do they buy,

1 what do they use, what are they into? What I meant was go
2 to Nike. We're going to have to really make a concerted
3 effort to go to them. And I think your point is so well
4 taken about the kids who don't have computers. Some kids
5 have the computers only at school. But to go to the sites
6 where kids are frequent, and I'm sure that you have all
7 that research of where the kids are, and to pursue heavily
8 that line.

9 DR. GARY: Yes. I think the other part of my
10 point was that if you have a child who is living in a
11 family who witnesses violence in the family, in the
12 community, on the street corner, or a child who tells me I
13 can't walk from home to school without one or two men
14 propositioning me, but everybody tells me not to tell, then
15 what does this 12- or 13-year-old male or female do when
16 all of the authority figures in his or her life say don't
17 tell kind of thing? I think we have to understand that
18 there are some social determinants that influence these
19 youths' behaviors that somehow we have to penetrate and
20 make it safe for them to tell and for them to get help.
21 So, again, some children live in violent communities, and I
22 think we have to penetrate that to make a difference.

23 DR. CLINE: Thank you.

24 And Ms. Huff, would you be okay with the last
25 question for this panel? Okay.

1 MS. HUFF: I'll reiterate because my comments
2 were much like hers, having been the director of the
3 Federation of Families for Children's Mental Health that
4 serves a lot of families who are poor and, obviously,
5 children who are poor.

6 I'd like for you to look into exactly where it
7 is that poor kids are, Boys and Girls Clubs and places like
8 that where if they're going to access technology, it's
9 going to be someplace like that.

10 I think what we also know is that many of them
11 don't read very well. So we're going to really have to
12 take heed to that. They may not read beyond the second
13 grade level, unfortunately, and they're trying to access
14 the kinds of things that we're talking about here. It
15 makes it impossible.

16 So I think you need to put together some focus
17 groups in places like New York City. I know our family
18 organizations would probably help put something like that
19 together with you to ask kids and families in poor
20 communities. And we all know how to get people to those
21 kinds of meetings -- our family organizations do -- and how
22 to get kids to those kinds of meetings.

23 But I think you need to ask the questions about
24 the very thing that Faye was mentioning because I've found,
25 when I was directing the Federation, so many things with

1 technology were just plain and simply white, middle class
2 things or upper middle class. People would look at me
3 around that and I would just have to say, you know, three-
4 fourths of the families we used, we mailed to, and even
5 that's hard. We just don't think along those lines very
6 much.

7 Asking this beautiful young woman, who is so
8 very articulate, and putting side by side to her a young
9 person who is her age who is African American poor and
10 doesn't know where their next meal is going to come from is
11 kind of like Ken said, people who are interested in
12 homelessness -- well, I'm interested in you having
13 something up there for folks that are homeless. That's a
14 whole different thing. I'd just ask you to probe beyond
15 your imagination even.

16 MS. TRUITT: And I think this might be where
17 student organizations could come in too where there are
18 underserved youth who can't have the technology access, if
19 we could work and get these resources to organizations like
20 FCCLA and dozens of other ones that were represented at the
21 HAY conferences, then that could be maybe an extra link to
22 get information to those students who aren't able to get it
23 otherwise.

24 DR. CLINE: I'd like to thank all of our
25 council members for their very thoughtful and very rich

1 suggestions. I think there's a lot of material, Larke, for
2 you to certainly incorporate and take back. Would you like
3 to have a final word before we close?

4 DR. HUANG: I just want to thank you all for
5 your input. I do want to just mention that this is a
6 program that we've brought to our grantees also because it
7 really is around pulling resources together to develop
8 community collaborations and coalitions and having the
9 tools to do that. So we're also trying to get good uptake
10 within our various grant programs that are focusing on
11 children and youth. Thank you very much for your input.
12 It's very helpful.

13 DR. CLINE: I thank all three of you.

14 (Applause.)

15 DR. CLINE: We will reconvene at 1:45. Thank
16 you.

17 (Whereupon, at 12:03 p.m., the meeting was
18 recessed for lunch, to reconvene at 1:45 p.m.)

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1 own personal connection because my extended family is
2 actually over there. Many representatives of that extended
3 family are in Iraq as we speak.

4 I just returned from my 30-year reunion of the
5 class of '77 at West Point, and we heard from one of our
6 stalwart classmates, Major General Rick Lynch, who is now
7 in command of Multinational Division South, I believe it
8 is, which is primarily the U.S. Army's 3rd Infantry
9 Division operating south of Baghdad. He gave us a strong
10 report.

11 I have a classmate of mine who was in my
12 company. His son deployed into Iraq about two weeks ago, a
13 brand new 2nd lieutenant, fresh out of West Point, class of
14 2006, went to his infantry officer basic course and on to
15 airborne school and ranger school, and dropped right into
16 his platoon while they were in combat. So I have a
17 personal connection to the fine young men and women who are
18 serving over in that conflict.

19 When I came to SAMHSA early last year, Charlie
20 Curie, of course, became aware of that background, and he
21 asked me to chair the Veterans Working Group to get
22 something up and running to serve veterans and their
23 families and address their needs. So we got that up and
24 running, thanks to the help of an awful lot of folks. I
25 think Dr. Elizabeth Lopez -- hopefully, she's here. But

1 she was very instrumental in helping organize that. And
2 representatives from all of our centers and offices who
3 make that working group happen. Of course, again, we're
4 appreciative of Dr. Cline for his strong support of the
5 efforts.

6 Kathryn Power, whom you will hear from shortly,
7 has been a strong supporter from the start and now
8 co-chairs that working group with me and leverages her
9 expertise, which is extensive as a state commissioner and
10 now, of course, the Director of the Center for Mental
11 Health Services, as well as the federal partnership that
12 moves forward and helps enable the entire federal
13 government to move forward en masse, if you will, on mental
14 health transformation. So these are all very positive
15 developments.

16 The working group was formed last year
17 following a national conference sponsored by SAMHSA in
18 partnership with the Department of Veterans Affairs and the
19 Department of Defense last March, March of 2006, brought
20 over 1,000 people together here in Washington, D.C. and
21 addressed the needs of veterans and their families and
22 presented a wide array of presentations on really the full
23 spectrum of concerns in delivering care and services, but
24 especially mental health services and substance abuse
25 services to veterans and their families. So that was

1 really the first event.

2 But our working group now took a look at what
3 else -- and other things could be done. We asked the
4 question, what else can SAMHSA do? What's the need? What
5 are the concerns? What's not being done? What could be
6 done better? So that was really our focus.

7 Now, we have some slides that are in your
8 books, and I'm not going to go through each of the slides
9 but I'll just refer you to them. You've probably already
10 taken a look at them.

11 But we wanted to, as a working group, start
12 looking at additional steps that could be taken. So we
13 initially reached out to the Department of Veterans
14 Affairs. I see Dr. Lehmann here and we reached out to him
15 and to Dr. Ira Katz and others at the Veterans Health
16 Administration. We reached out to the Department of
17 Defense, both entities of which already had a good
18 relationship going with the Center for Mental health
19 Services as part of the federal partnership. But we wanted
20 to understand the full scope of the problem that we were
21 confronting. We wanted to learn what all the needs were.
22 So we did that.

23 We also figured if we're going to address the
24 needs of veterans, then, well, maybe we ought to talk to
25 some. So we sponsored here at SAMHSA a few months back a

1 forum for veterans service organizations, and their
2 representatives all came in. They heard from us on what we
3 were doing, but most importantly, we heard from them on
4 what their concerns were and what their needs were. Of
5 course, we also at that had representation from the
6 Department of Veterans Affairs, DOD, and of course, Dr.
7 Clark and Kathryn were very instrumental in helping with
8 that, along with Dennis Romero and CSAP.

9 We had a great conference. We came out, I
10 think, from that with a clear understanding of the things
11 that we needed to do. I won't go into great detail, but
12 suffice it to say, the Department of Defense has some
13 excellent facilities that provide a broad array of health
14 care, including mental health care, to active duty service
15 members. They really do. And for their families, there's
16 the TRICARE insurance program. Maybe it isn't perfect, but
17 it really provides some top-notch coverage, and I can
18 attest to that personally because I'm covered by TRICARE
19 after 20 years in the military. So that's ongoing.

20 Of course, the Department of Veterans Affairs
21 has some excellent facilities all over the country,
22 delivering some top-notch service. But there are still
23 returning veterans who, for one reason or another, aren't
24 using any of those facilities or aren't going there. And
25 there are family members who aren't necessarily receiving

1 the coverage they need.

2 So our question is, what's the role of SAMHSA?
3 What can we do? What should we do? As we got into it, we
4 learned that the question is even broader than SAMHSA
5 because we've come to realize that SAMHSA is involved, HRSA
6 is involved through their health centers around the
7 country, the Indian Health Service is involved. Lots of
8 veterans are American Indians or Alaska Natives, and they
9 return to their tribal lands and they seek services
10 locally. Another issue that is down the road that will
11 have to be addressed sooner or later is Medicaid. So CMS
12 is involved. You know, there's a role for the Department
13 of Health and Human Services here, and we need to flesh out
14 what that is. We need to understand what that is. So we
15 continue forward to really determine what more needs to be
16 done.

17 Let me talk to you a little bit more about some
18 of the things we've already started. Here at SAMHSA, we're
19 identifying or have identified veterans as a priority
20 population to be served by our other programs, whether
21 they're substance abuse programs or mental health service-
22 related programs. We've established, in partnership with
23 the Department of Veterans Affairs, a suicide prevention
24 hotline. They're actually plugged in to SAMHSA's Suicide
25 Prevention Lifeline, which Kathryn can talk a little bit

1 more about, but that Lifeline connects veterans who may be
2 in crisis with VA providers and a system of almost 200
3 crisis counseling centers that we have established all
4 across the country. So that's huge. That's a great
5 accomplishment. We've established a web page here on the
6 SAMHSA website.

7 We're looking at a second national conference,
8 but this time with a focus on strategic planning by region.

9 We're looking at hosting that here in Washington, D.C.
10 probably next summer, hopefully next June. We're still in
11 the process of coordinating that. We're just at the very
12 start of that, but we think that's going to be huge. And
13 we want to do that in partnership with the Department of
14 Veterans Affairs and their VISNs, their Veterans Integrated
15 Service Networks, around the country, as well as DOD and
16 state agencies and community providers. We figure if we
17 can break out some planning seminars by region, we can
18 really facilitate some really good planning, but also some
19 great communication, perhaps some relationship-building,
20 and maybe facilitate some of that integration that needs to
21 be done especially at the regional and state level. So
22 we're pretty excited about that.

23 Going back to this role for the Department of
24 Health and Human Services, we've got some great support now
25 from the Assistant Secretary of Planning and Evaluation.

1 We call him ASPE up in the Office of the Secretary.
2 They've realized that this is broader than SAMHSA. It does
3 pertain to other entities within the Department of Health
4 and Human Services, and of course, as I stated before,
5 there is this niche there for HHS in between the Department
6 of Veterans Affairs and DOD. Even though they're the lead,
7 there are still returning veterans and family members who
8 will not avail themselves of their facilities. So we have
9 to be ready because they'll come our direction anyway,
10 quite frankly.

11 We are engaged now in a collaboration with
12 ASPE, and we're at the very start of it. We are joining
13 with them to conduct what I call really an analysis of the
14 need. You know, as an old engineer, in addition to some of
15 the other things I've done, I've learned you always start
16 out with a needs analysis. So we're going to join with
17 them and bring some folks on board to take a look at all
18 the data that exists right now out there throughout the
19 country to help us determine what the real need is and what
20 the HHS role can be, the SAMHSA role and also the role of
21 the other entities within the Department of Health and
22 Human Services. So that's something that we hope will lay
23 the foundation for what we will do in the next couple of
24 years.

25 There are other things that SAMHSA is

1 contemplating, but in order to really bring them about, we
2 need this solid basis. We need this data, this foundation,
3 if you will, of information to inform us on what the best
4 next step would be because we would like to move forward
5 with another initiative or two to address some of the need
6 that's out there.

7 Something else that has occurred over the last
8 year is the report done by the Department of Defense that
9 has looked at mental health care within the Department of
10 Defense. Our representative, a member of that task force,
11 has been Kathryn Power. At this point in time, I'd just
12 like to turn everything over to her to give us a full
13 report on what all that entailed.

14 MS. POWER: Thank you very much, Arne. Good
15 afternoon, everyone.

16 Last year the National Defense Authorization
17 Act was amended by Senator Barbara Boxer of California,
18 which basically directed the Department of Defense to
19 establish a task force to examine matters relating to
20 mental health related to the armed forces of the United
21 States. In fact, in creating that task force, Senator
22 Boxer and Senator Lieberman both intended that there would
23 be a full effort to take a look at the efficacy of mental
24 health services across the active duty military.

25 I was very privileged to be appointed to that

1 task force and worked for the last year on that task force
2 with a group of seven military and seven civilian
3 participants, all of whom are much smarter than I am and
4 much more credentialed than I am, related to mental health
5 and to military medicine, to combat psychiatry and to
6 public health.

7 The first chair of the Mental Health Task Force
8 was Lieutenant General Kiley who was the Surgeon General of
9 the Army and later had to leave actually that position at
10 the time of the Walter Reed difficulties. Then he was
11 followed by the Surgeon General of the Navy, Vice Admiral
12 Arthur. We were led in this effort by both of those co-
13 chairs, as well as by Professor Shelley MacDermid, who is a
14 university professor at Purdue who does family studies and
15 military issues. Really a stellar group of people.

16 We met regularly as a group, but we also did a
17 tremendous amount of inquiry relative to information about
18 what we were going to say and how we were going to say it
19 through five different specific methods.

20 The first thing that we did was we visited 38
21 sites across the globe, so different military
22 installations, most of them either Army or Marine Corps
23 because that, of course, is the bulk of where the forces in
24 Iraq and Afghanistan come from, even though the Navy, of
25 course, delivers the Marine Corps health care system. So

1 we visited a majority of naval installations as well, or at
2 least the medical centers. But we focused on trying to
3 gain information from those site visits, and very extensive
4 travel was involved in this task force.

5 We also derived our information from subject
6 matter experts. That is, we brought in individuals who
7 serve in the military. We brought in their family members.

8 We brought in academia. We brought in researchers. We
9 brought in as many subject matter experts as we could and
10 also took a look at specific areas of treatment, specific
11 areas around prevention, specific areas around promotion,
12 and tried to get the best and the brightest to testify in
13 front of the task force.

14 We also reviewed existing literature, and I
15 would recommend to you, if you read nothing else in the
16 report, that you read the findings and you look at the rich
17 resources of the literature. It was the one thing that our
18 co-chair insisted, that we had credibility in the
19 literature, that we weren't just -- it was important to
20 listen to anecdotal stories, but it was also important to
21 look at the literature and to see what kind of research has
22 gone on and what kind of literature is available. The
23 appendices in this report I think are going to serve for a
24 long period of time as a tremendous piece of work.

25 We also took public testimony and public

1 submissions to the task force directly, and we also had a
2 website where individuals could testify or give us their
3 information about the kinds of efficacy of mental health
4 services, which was really the core question, that they had
5 either witnessed or that they had themselves received.

6 Then we also had very specific requests that we
7 sent out to both military and civilian organizations as
8 they arose during our deliberations. So we would do a data
9 call back out to the uniformed services, keeping in mind,
10 of course, even though this is all under the Department of
11 Defense, everyone has their own military approach to
12 medicine. So if we needed information about deployments,
13 we would go to the Army or the Marine Corps. If we needed
14 information about the suicide prevention program in the Air
15 Force, we would go to the Air Force. So we would do a host
16 of data calls that would give us this. So those were
17 really the sources of our experience in terms of getting
18 information from as many people as we possibly could.

19 The report was delivered to Congress, basically
20 delivered to Secretary Gates and also simultaneously to
21 Congress on June 14th of this year. You cannot find these
22 copies anymore. They are not printing them anymore. That
23 is how much it was in demand in the first printing. This
24 basically was printed out of the Defense Epidemiological
25 Board of the U.S. Army, and you can download it but they

1 are not printing any more copies right now because there
2 were so many that were distributed that initially.

3 So the report was delivered to Secretary Gates,
4 and at that time, Secretary Gates had a press conference,
5 which normally if we were doing the PowerPoint, you would
6 see. But basically Secretary Gates said thank you very
7 much for the work. This is an important next step. He has
8 now six months to develop an action plan and to begin
9 telling us how he will implement the recommendations of the
10 action plan. He basically was, I think, impressed with the
11 depth of the work that the task force did, and he said he
12 didn't want to wait until six months, but that he wanted
13 the task force report to go immediately into a working
14 group and he has given them less than three months to do
15 it. So we're looking forward, even as we speak, to hearing
16 about some of the recommendations being put into play.

17 We also know that Senator Boxer and Senator
18 Lieberman have a continued commitment to doing something
19 with the task force report.

20 We also noted that there was an enormous amount
21 of media attention that came out post the delivery to
22 Secretary Gates.

23 And we are worried as task force members that
24 because there were so many other commissions and so many
25 other groups that were tasked with looking at other

1 component parts of health care and other facility issues
2 that were arising, particularly out of Walter Reed and
3 others, that we do not want this task force report to
4 disappear. This is the only task force report that has
5 ever focused solely on mental health. Of course, we looked
6 at substance abuse as well. But the reality is that we do
7 not want the needs of individuals in the military to get
8 lost in the shuffle relative to all of the other
9 commissions. I think there are nine other commissions that
10 were appointed by the President or by Congress to take a
11 look at the broader health care needs of returning vets and
12 active duty personnel, and we want to make sure that this
13 report stays very much alive.

14 I'm going to talk very briefly about the vision
15 that was created in this task force report. We basically
16 adopted the Healthy People 2010 definition of mental
17 health. That was the framework of our beginning
18 deliberations. Part of that was an interesting debate
19 because the military may define mental health totally
20 differently than the civilian community. So we had to
21 really adopt a definition that was accepted by all of the
22 members of the task force, and that seemed to be the best
23 approach to take, was to adopt that definition.

24 We also had some long conversation about
25 recovery and resilience as it relates to not only SAMHSA's

1 mission but also to the way in which the President's New
2 Freedom Commission report on mental health talked about
3 recovery. We found that because we were working with two
4 organizations, basically the Department of Defense who has
5 been undergoing transformation for over 20 years and the
6 Veterans Administration who were a very vibrant part of
7 this task force, who are undergoing their own
8 transformation relative to the Veterans Administration. So
9 it was very key that we were able to take some of the
10 language from the New Freedom Commission and adopt it and
11 adapt it immediately into our discussion.

12 Our deliberations really resulted in four major
13 goal statements and four major recommendations. I'm going
14 to talk a little bit about those.

15 The first is that the DOD task force believes
16 that the active duty military has a responsibility to
17 create a culture of support for psychological health. That
18 is the term that we ended up adopting in the framework of
19 the mental health definition, but we adopted the term
20 "psychological health" basically because the Surgeon
21 Generals, both of them, believed that it was an important
22 framing for talking to Congress and for talking across the
23 services, that psychological health would be a term that
24 would be more acceptable and therefore would, in fact,
25 resonate. This culture of support for psychological health

1 really has been defined as including every single service
2 member, and every single individual in a leadership
3 position will be educated to understand that psychological
4 health is essential to overall health and performance.
5 That's goal one of the New Freedom Commission report.

6 Now, for the military to say that they are now
7 going to train their leadership and they are going to train
8 every single member to understand that psychological well-
9 being and psychological health are intrinsic to overall
10 health and performance is a major move. The notion of
11 early and nonstigmatizing psychological health assessments
12 and referrals to service are going to be routine and
13 expected. I can't tell you how compelling it was to hear
14 from members of the services say, you check my teeth twice
15 a year. You never check my brain. And we pay, both in the
16 active duty and in the reserve, for twice annual physical
17 assessments. We have never done that for psychological
18 assessments. So the issue around normalizing a
19 psychological assessment within the military is a very,
20 very large step.

21 In fact, we got around the resource debate
22 about, well, how can we possibly do that. We can't
23 possibly have the resources. And we said you need the
24 resources because if you don't invest in the overall mental
25 well-being of the individuals, then you in fact are not

1 investing appropriately in the overall health of
2 individuals in the military. So creating a culture of
3 support for psychological health was the first large goal.

4 The second goal is that service members and
5 their families will be psychologically prepared to carry
6 out their missions. Service members and their families
7 will receive a full continuum of excellent care in both
8 peacetime and wartime, particularly when service members
9 have been injured or wounded in the course of duty.

10 Basically what this gets to is this notion of
11 understanding and beginning to value the psychological
12 well-being of members who, in fact, need the support of
13 their families and need the support of their communities
14 and need to have access to a full continuum of care. There
15 was a lot of debate about the lack of a continuum of care,
16 and the fact that the individuals could not get the care
17 they needed at the time they needed it from the individuals
18 that should have been providing it was certainly a message
19 we heard from the active duty. I think it speaks to
20 something that Arne said about the fact if individuals,
21 both in the active duty and within the veterans community,
22 cannot get the care they need at the time they need it,
23 it's simply not healthy.

24 In fact, both the active duty and the Veterans
25 Administration talked about the fact that we have to ensure

1 that the training programs are improved so that we can
2 retain and expand the number of mental health and substance
3 abuse practitioners in both the active duty military and
4 the VA so that the capacity will be expanded. There's an
5 enormous number of recommendations around the capacity of
6 behavioral health expertise in the active duty military.

7 The third vision is sufficient and appropriate
8 resources will be allocated to prevention, to early
9 intervention, and to treatment in both the direct care
10 service system -- and by that I mean the active duty
11 service system -- and the TRICARE Network systems and will
12 be distributed according to need. This basically came
13 about because there were distribution models in both the
14 active duty side and in the TRICARE side, which is a
15 contractor for health care services, that there was a
16 maldistribution of appropriate practitioners and there was
17 a maldistribution across the services.

18 So, for example, there are no social workers,
19 frankly, in the Navy. There are very few social workers in
20 the Air Force. So the biggest program for social workers
21 is in the Army. So why is that? Why is it that we have
22 one military service utilizing social workers in a very
23 specific way, in a case management way, but the other
24 services have not developed that? It was one of the most
25 fascinating discoveries to see just how diverse our

1 uniformed services are relative to health care and relative
2 particularly to behavioral health care and relative to
3 mental health and substance abuse.

4 So the notion that we were recommending that
5 sufficient and appropriate resources will be allocated to
6 prevention, early intervention, and treatment gets at the
7 heart of the continuum of care and gets at the heart of the
8 continuum of services that are really necessary. In fact,
9 there are huge gaps in both the direct care system in the
10 active duty military, as well as in TRICARE.

11 Then the final and fourth area of the vision
12 goal was that at all levels, visible and empowered leaders
13 will advocate, monitor, plan, coordinate, and integrate
14 prevention, early intervention, and treatment. Very often
15 from the military standpoint, mental health care was
16 isolated in a behavioral health environment and was not
17 really thought of -- in other words, the continuum of
18 mental health status was not really thought about in terms
19 of prevention, early intervention, and oftentimes was only
20 focused on specialized psychiatric services.

21 So the notion that at first point of entry into
22 the military, that you are educated and informed about the
23 importance of your own mental health status and that you're
24 in an environment which is not punitive and you're in an
25 environment which recognizes that it is courageous and it

1 is appropriate and it is meaningful to care about one's
2 mental health status, even as a working member of the
3 military, is a change. In fact, it is, I think, a
4 significant and substantive change, and already there is
5 much discussion going on inside the Pentagon relative to
6 the development of the training programs which will be
7 offered at the academies from now on, that will be offered
8 across the opportunities to train everyone in an awareness
9 about mental health and its importance to overall health.

10 There are 94 recommendations in this report.
11 Every single one of them I think has substantial findings
12 from our deliberations and has a series of steps that need
13 to be taken relative to how to make things happen. They're
14 actually listed under either actions or policy or
15 legislation. So you'll see in the report that we make
16 recommendations about particular legislative and regulatory
17 changes particularly around contracts with TRICARE. We
18 make policy recommendations, and we make action
19 recommendations. I'm just going to give you just a sample
20 of a couple of those.

21 The first is that we have to embed the
22 psychological health training throughout military life.
23 That means you won't just have one shot but throughout your
24 entire military career, you will, in fact, be given
25 psychological health training as you continue through your

1 military experience. We saw that the military did not
2 necessarily have the most up-to-date policies, the most up-
3 to-date knowledge, the most up-to-date evidence-based
4 practices about psychological health. So we've made a
5 recommendation on a number of areas around the kinds of
6 evidence-based practices that need to be incorporated
7 across DOD.

8 The psychological screening procedures. We
9 have to make them a normal part of military life. How are
10 we going to do that when we have no one who's currently
11 doing that? So the Pentagon really has responsibility for
12 now mapping out. As a Reserve officer, I get myself
13 checked twice a year. Well, certainly when I go in to get
14 myself checked twice a year from the military, we should be
15 able to offer a small screening or assessment tool at that
16 point to do a mental health status check. This should not
17 be a budget buster. This should be something that we
18 should be able to handle. I think that's the kind of
19 response we're looking for from Secretary Gates.

20 We know that a couple of the recommendations --
21 for example, DOD has been asked to develop its own public
22 service anti-stigma campaign. So they've asked for
23 examples from many of the members of the committee. They
24 want to do a public education campaign using evidence-based
25 techniques to provide factual information about mental

1 health status and about mental health disorders. So those
2 are the kinds of things that you're going to see the
3 military taking on.

4 They're going to develop a DOD-wide curriculum
5 on psychological health as an integral part of overall
6 health and leadership training.

7 I think one of the most astounding
8 recommendations and certainly one of the most profound in
9 terms of our discussion was the fact that we recommended to
10 Secretary Gates that the question about having ever seen a
11 mental health practitioner or provider that is on every
12 security screening questionnaire in the military be
13 removed. Secretary Gates basically said he thought that
14 that was a worthy recommendation, and in fact, it would
15 help lessen the stigmatizing attitude about seeking mental
16 health care. And we were very pleased that he responded in
17 that way at his press conference. So there is some work
18 being done within DOD about what can or can't be removed
19 relative to a security questionnaire about the fact that
20 one has sought mental health care in the past.

21 I'm not going to go over a lot of these
22 recommendations, but I think that suffice it to say that
23 this report I think sets a new standard, sets a new level
24 of concern and care for the overall psychological health,
25 psychological well-being, and mental health of our active

1 duty military. I think it will have an impact eventually
2 in terms of people who leave active duty and go into the VA
3 so that if we can be teaching people about their own mental
4 health status, I'm hoping that an educated workforce around
5 mental health will help mitigate perhaps some of the mental
6 health issues that arise later.

7 We do have a difficulty in that each branch of
8 the service is its own center of programmatic innovation,
9 which is Admiral Arthur's way of saying that each service
10 goes off and does its own thing. And that is a problem,
11 and it is going to be a problem relative to how much
12 Secretary Gates can hold the various services' and the
13 various Surgeon Generals' and the various chiefs' feet to
14 the fire to do the kinds of things that need to be done at
15 the DOD-wide level and at the same time have the individual
16 services do the kinds of things that they need to do
17 relative to their own program, relative to their own
18 budgets, and relative to their policies.

19 There is a huge shortage of mental health
20 professionals in the active duty military, and training
21 programs over the past few years have been cut. The notion
22 that we have to cultivate not only having appropriate
23 mental health professionals and behavioral health
24 professionals inside the active duty military but also the
25 fact that the VA is also recruiting for more and more

1 behavioral health professionals -- there's a demand.

2 There's just a huge demand across the military.

3 So what will happen? I don't know what will
4 happen in terms of the kinds of programs. They might be
5 able to put together some incentive programs. I have two
6 members of my family that actually are military physicians,
7 and there are good programs that are available but they
8 simply do not have the numbers of people that they need.

9 They have a particular need for minority
10 professionals. Twenty-five percent of deployed armed
11 forces members are members of minorities. We have very few
12 minority practitioners in the military, particularly the
13 active duty military.

14 We don't have enough people who know about
15 children and the effects on children and families,
16 particularly with multiple deployments. Over 700,000
17 children have at least one parent who's deployed or who has
18 been deployed. That's a lot of kids with a lot of issues
19 related to school and their emotional life. So we don't
20 necessarily have that level of expertise inside the active
21 duty military at this point and we need to do something
22 about encouraging that expertise.

23 We know that there's increased drug usage among
24 active duty members, and binge drinking and smoking rates
25 are continuing to increase among active duty members.

1 Those issues have to interplay with the kind of prevention
2 and education messages that the military certainly pays
3 attention to.

4 Women now constitute 16 percent of the members
5 of the armed forces and are in 90 percent of the military
6 occupations. Frankly, in this war they're as exposed as
7 anyone else to the tragedy and to the injury potential. We
8 had a lot of testimony around sexual trauma and sexual
9 violence against women in the military, and we've made some
10 specific recommendations in this report that the military
11 needs to step up their activity and get much more
12 knowledgeable about and much more savvy about the way in
13 which they're supporting and intervening in the sexual
14 trauma issues for women.

15 I think one of the most important statistics
16 out of all of this is that three out of every five deployed
17 members of the armed forces have a spouse, a child, or
18 both. So the whole issue of the impact on the family and
19 the impact on the mental health needs of members of the
20 armed forces and their families as a unit really needs an
21 enormous amount of work, and I think that that's really
22 where our continuing efforts with both the Department of
23 Defense and the VA are going to bear fruit.

24 As Arne suggested, we're in partnership with
25 the DOD and VA. Our job is to be a partner with them and

1 our job is to help in whatever way we can and to offer any
2 supports that we can. Particularly when it comes to things
3 like evidence-based practices, when it comes to things like
4 public service campaigns, when it comes to technical
5 assistance on the next generation of military mental health
6 and substance use services, when it comes to our connection
7 with the states and with NASMHPD and NASADAD and the state
8 organizations, when it comes to those state and community
9 systems, we can be a partner with DOD and VA because the
10 need is enormous.

11 We talked about the tsunami that's coming
12 relative to the demand for services not only in the active
13 duty military but certainly for the VA. We know that there
14 will be a percentage of people who will not go for services
15 to the active duty military or to the VA. So we need to be
16 particularly sensitive to the members of the Guard and the
17 Reserve and those individuals who return home to their
18 communities who in fact will be in need and who in fact we
19 do have connection to through some of our other grants. We
20 have people coming through other grants, Safe
21 Schools/Healthy Students, children's mental health grants.

22 All of a sudden people are stepping up and coming forward
23 and saying we need your assistance, we need your help. We
24 see ourselves I think in partnership with both DOD and VA
25 in a very solid way.

1 So with that, Arne, I'll turn it back to you.

2 MR. OWENS: Well, thanks so much, Kathryn. I
3 think it was very insightful.

4 To give you an idea as to the scale -- as I had
5 mentioned before, we're in partnership with ASPE to really
6 come up with a solid basis for the HHS piece of this
7 challenge. But to give you an idea of the scale that we
8 know about now and the idea of how many people are
9 affected, let me just quote some statistics. I think
10 actually the way these statistics are broken out is
11 informative to the issue of stigma that Kathryn was just
12 talking about.

13 I pulled off of the web page from DOD today the
14 current tally as of 10:00 a.m. this morning of fatalities
15 in Operation Iraqi Freedom. There have been 3,759 deaths.
16 That's total deaths. That's both killed in action and
17 deaths due to nonhostile action. There have been 15,291
18 wounded in action and returned to duty, and there have been
19 12,476 wounded in action and not returned to duty. Those
20 are the very seriously wounded, seriously injured, perhaps
21 even permanently disabled who will most likely be
22 discharged.

23 In Afghanistan, it's a much lower number, of
24 course, 435 deaths and about 1,600 total wounded in action.

25 What's interesting to me is that there is no

1 category for numbers with PTSD, people presenting with
2 mental health issues. There is no number listed on the
3 official tables. But the DOD report gave us a good
4 snapshot.

5 Now, remember, there have been about 1.4
6 million military personnel who have served in one capacity
7 or another in Operation Iraqi Freedom or Operation Enduring
8 Freedom. That's Iraq and Afghanistan. About 1.4 million.

9 Now, a lot of that is Air Force. A lot of it is Navy.
10 The primary focus for PTSD, traumatic brain injury, those
11 sorts of things are your ground combat forces in the Army
12 or the Marine Corps.

13 The DOD report was interesting. Data from the
14 post-deployment health reassessment, which is administered
15 to service members 90 to 120 days after returning from
16 deployment, indicates that 38 percent of soldiers and 31
17 percent of marines report psychological problems. And
18 among members of the National Guard, the figure rises to 49
19 percent. That's fairly significant.

20 We'll get more data on that as we go ahead, but
21 especially for the National Guard and also for other
22 members of the military who leave active duty, either their
23 enlistment is up -- they may have been in the regular Army
24 but their enlistment is up. So they're going to return
25 home. There is a chance that they will show up on the

1 doorstep of a community mental health center. Worst case,
2 they're going to be in crisis and there's no help
3 available. They'll get picked up by the county sheriff.
4 That's not something we want to have happen. We want to
5 prevent that. We want to have services in place that will
6 help address that. So that's our challenge and that's why
7 we're doing what we do.

8 We had hoped to present a face to you so you
9 could visualize a veteran who has experienced services in
10 the mental health system. He's unable to be with us here,
11 unfortunately. He was an eight-year veteran of the U.S.
12 Marine Corps. He served two tours in Iraq as a petroleum
13 specialist and as a combat engineer. He's currently
14 working with the Vets for Vets, a veteran service
15 organization, advocating for just what we're talking about,
16 expanded mental health services for veterans around the
17 country. He's unable to be with us, and that's
18 unfortunate. So we're going to move to our dialogue, which
19 is just as important.

20 But I want to just reemphasize again this whole
21 problem, this whole challenge involves more than just the
22 veteran. It involves veterans' families. I have a picture
23 of what this looks like. I've been there myself in Desert
24 Storm, so I know what it looks like on the ground in Iraq.
25 When I talked to you about my classmate's son, I can

1 visualize him because I can see the young son of my
2 classmate and I know what my classmate looked like 30 years
3 ago. So I can see young Patrick Swanson out there in the
4 desert of Iraq, and I can just imagine what he looks like
5 right now. So, I mean, I can see these guys. The cost is
6 being paid but not just by the veteran, not just by the
7 service member. It's also being paid by the family.

8 Every two months, if your an academy grad, you
9 get a copy of Taps. It's sent out as part of the alumni
10 association's magazine. It lists the obituaries of past
11 graduates of the military academy, and you thumb through
12 it. You're not surprised by most of it. I mean, there's
13 the class of '39, class of '40, '44. I mean, this is the
14 greatest generation and they're passing on, and you expect
15 to see that.

16 But then you get back here and you see David M.
17 Frazier, class of 2004, and you realize that these guys are
18 going off into something and it's a challenge. And they
19 expect their families to be taken care of when we send them
20 off there to do this job. I would just point out that
21 young Captain Frazier is survived by his parents who are in
22 Houston, Texas, his brother and sister-in-law in Austin,
23 grandmother in Casper, Wyoming, cousins in San Antonio,
24 other cousins and uncles and aunts in Flagstaff, North
25 Carolina. So a whole number of people, a much broader

1 number of people have been affected by this one death.
2 Just multiply that by 3,759 and extend that connection to
3 all the families around the country, and you can see
4 there's a serious challenge. And we want to be able to
5 have the best possible services in place that we can offer
6 in order to be of help in the years ahead.

7 We'd like to transition at this point because
8 it's important to hear from you. There are a series of
9 questions on the agenda, and Kathryn is going to take the
10 first one. But we'd really like to focus on states and
11 communities and the needs there. Kathryn will lead the
12 first one and I'll take the second two. We would just
13 really encourage you to think, to share with us your
14 thoughts, and we will capture those and do everything we
15 can to put them into effect.

16 Kathryn?

17 DR. CLINE: Kathryn, just to say we have about
18 25 minutes for this part of the agenda. I'd like to thank
19 you and thank Arne for your thoughtful presentations and
20 the information. I'm guessing that you've raised more
21 questions than you've actually provided information to
22 address, which is part of what we hope to hear from our
23 council members. We have about 25 minutes for the
24 questions.

25 MS. POWER: Okay. I think it will be a

1 combination. You see the questions in your agenda. I
2 actually raised a couple of them in my comments, and I'm
3 probably going to bleed, Arne, a little bit over into the
4 second one as well.

5 We're asking you for your ideas about the
6 states' and communities' needs regarding substance abuse
7 and mental health prevention and treatment services for
8 returning vets, what's your experience, and what are some
9 of the things that you've observed and that you feel very
10 strongly about. We're looking at what role these
11 organizations can play in addressing these needs and some
12 of your ideas.

13 I also want to just add that I think that you
14 know that SAMHSA has, for a long period of time, been
15 involved in looking at trauma and looking at trauma-
16 informed services and supporting trauma-sensitive services.

17 That really is, I think, one of the most important places
18 where, in talking with people in the military, that getting
19 out the sensitivity to trauma and the universality of
20 trauma, there is no one who returns from these experiences
21 who does not experience trauma. It is a universal
22 experience.

23 Those individuals who are, in fact, diagnosed
24 with PTSD -- and we spent an enormous amount of time in the
25 task force talking about that. There are very effective

1 services. There are very good services that are available
2 for PTSD not only in the active duty military but also in
3 the VA. But this connection for us in terms of trauma and
4 building trauma-informed services I think is one of the
5 places where some of our community providers, Arne, can
6 really get at some of that.

7 So let me just ask you all about your opinions,
8 your ideas. I know we all have our own experiences. So
9 why don't we go from there.

10 DR. CLINE: Ken?

11 MR. STARK: In Washington State, we've got the
12 state Department of Veterans Affairs. John Lee is the
13 director and Tom Schumacher is the mental health manager
14 for the state Department of Veterans Affairs. They've been
15 heavily involved in the Transformation Project. They've
16 been a major player in the Mental Health Transformation
17 Project, pushing a variety of initiatives.

18 One of the issues that came up was -- I'm not
19 sure who is funding this, but there's a UCLA study that's
20 being done that's looking at the effects of deployment on
21 families, especially children, among active military.

22 MS. POWER: Right.

23 MR. STARK: But they weren't looking at any
24 National Guard families. So as part of the Mental Health
25 Transformation Project -- and SAMHSA's name will be on this

1 report as one of the funders through the transformation
2 grant -- we're funding a fairly small amount of money to
3 the UCLA folks to add a cohort of National Guard families
4 from Washington State so we can get a better sense of the
5 effects of deployment on National Guard families,
6 particularly children.

7 Even from the data that you talked about
8 earlier, Arne, it's clear that the effects of deployment,
9 especially multiple deployments, on National Guard families
10 -- and I would include Reserves on that -- is probably
11 greater than the active military especially for the
12 National Guard because in previous wars they weren't
13 engaged as families as much in deployment or multiple
14 deployments.

15 So that report -- we'll probably be getting
16 information on it sometime next spring, and that will be
17 helpful to not only the state Department of Veterans
18 Affairs in developing sort of a proposal or package of
19 resources to look at helping these families sustain
20 themselves, including when the deployed person or persons
21 are returning or not from the war.

22 The other thing that we've gotten involved with
23 is one of our priorities of our Transformation Workgroup
24 that was pushed by our Cultural Competence Task Force was
25 to come up with a web-based cultural competence training

1 package, if you will, that would include an organizational
2 cultural competence assessment as part of it on this web-
3 based tool. Again, our state Department of Veterans
4 Affairs said, look, if you're talking about cultural
5 competence, don't forget that there's such a thing as a
6 military culture and that it's different than a nonmilitary
7 culture, and you really need to take that into
8 consideration. So we've incorporated that into that
9 process.

10 The other thing is that -- like in many states,
11 I'm sure -- our state Department of Veterans Affairs,
12 again, has been extremely active in working with military
13 families, not just National Guard, including the person in
14 the military as well as the family members, in helping them
15 get access to their VA benefits because a lot of times it's
16 not as easy as it sounds. You're covered, walk in, you get
17 the service. Sometimes there are all kinds of questions
18 about are you really eligible for that service and can you
19 really get through the hoops to apply for the process. And
20 there are really some questions when you talk about some of
21 the older military folks from previous wars that, for
22 whatever reason, have some difficulty with their paperwork
23 as they try to access services much later on for mental
24 health and medical services.

25 So there is quite a bit going on in our state,

1 not near as much as I think we need to do, but there's
2 clearly a sense of obligation to doing something for the
3 National Guard folks, as well as active military, and a
4 number of champions that are pushing the issue and trying
5 to keep it in the forefront, including issues around trauma
6 which typically, at least in our state, in the public
7 mental health system, trauma in and of itself is not a
8 service that makes you eligible for Medicaid mental health
9 services.

10 MS. POWER: I think there's a universal
11 acceptance, I guess, Ken, and acknowledgement that it's
12 time for everyone to do something about this, whether or
13 not it's the active duty DOD, whether it's the VA, whether
14 it's communities, whether it's states. We had many of the
15 state Guard bureaus, at least a half a dozen of them,
16 testify and talk about the fact that the Guard bureaus and
17 the state mental health and substance abuse folks have
18 gotten together and talked, and whether they're using it in
19 the transformation context, they've actually made
20 connections with their regional VA. I mean, just beginning
21 to make those kinds of connections I think is also part of
22 this overall awareness. We found that there were Guard
23 bureaus that were very willing to say I will connect up
24 with the Reserve components. You know, they're out -- you
25 know, they aren't connected basically other than to their

1 active duty counterpart.

2 So I think everyone is just building a strong
3 sense of commitment and acknowledgement that these
4 individuals return to their communities, and we want to
5 participate with them in their reintegration, which is
6 really the term that we have now adapted, I think, in terms
7 of both DOD and VA and our federal Executive Steering
8 Committee. We all have a stake in reintegration, and I
9 think that's really important.

10 So kudos to Washington.

11 MR. OWENS: You know, hearing that, Ken, just
12 makes me even more excited for this conference that we hope
13 to have here next summer where we can get more experiences
14 like yours shared under one roof and just get even more of
15 that communication going. We know things are happening out
16 there in all the states and just hearing about it and
17 sharing the ideas is the direction we want to go.

18 DR. CLINE: Dr. Gary?

19 DR. GARY: Thank you very much.

20 I wanted to respond to the first bullet there
21 that Ms. Power will facilitate, and that is the notion of
22 what role can community-based substance abuse and mental
23 health organizations play in addressing the needs.

24 I've had a WOC appointment at the VA hospital
25 for about 25 years. One of the things that I recognized

1 when I was working there and participating in training
2 programs was that if a veteran goes to X facility in the
3 community, what the community provider would do is say,
4 well, this is a veteran. So let's just shunt him or her on
5 to the VA. Now, the VA could be 100 miles away or it could
6 be 50 miles away. It could be right around the corner. So
7 many things happen with regard to this shunting process
8 from one facility to the other.

9 So in response to the community-based, then I
10 would say that if we look at community mental health
11 centers, if we look at self-help organizations, if we look
12 at organizations such as NAMI, et cetera, we have to
13 provide some training for them also. Maybe it's web-based
14 or maybe it's a part of the required continuing education.

15 But unless we teach individuals who are currently involved
16 in these community-based mental health and substance abuse
17 programs, which might be the first point of contact for the
18 veteran -- they need to know exactly what to do, what the
19 services are, back to the point that Ken made.

20 I think one of the perplexing things is who is
21 eligible for service. You can be 10 percent service
22 connected for your eyes and 50 percent service connected
23 for your toes and having hallucinations. Then the issue
24 comes up can you get service at the VA. So I'd like to
25 hear some discussion about the service connection to the

1 different body parts and how that, in fact, mitigates
2 against services that the veterans can receive.

3 I know that social workers and nurses,
4 physicians spend a lot of time trying to sort out this
5 service connection piece, and it's very time consuming and
6 veterans get very despondent about it because they have
7 tremendous needs, but if they're not service-connected for
8 that particular problem, they may not be eligible for
9 services in the VA.

10 MS. POWER: I think Larry is the expert in
11 this, but I will tell you that you've hit a very germane
12 point relative to both the Department of Defense and the VA
13 understanding fully the impact of mental health issues on
14 the overall health and what is the triggering diagnosis
15 versus injury. We had just enormous debates in the task
16 force about that. I think you raise a very important
17 issue.

18 We're counting on both the active duty and the
19 VA to continuously update their own understanding of the
20 trigger events and effects that, in fact, can have an
21 impact on their emotional and functional and behavioral
22 ability over time. I think that that sensitivity was felt
23 by both the active duty military and the VA around
24 appreciating and understanding the longer-term effects of
25 trauma and how that, if it's not treated immediately or if

1 it's not recognized or appropriately treated immediately,
2 can have really debilitating effects physically over time.

3 That really gets back to your issue about service-
4 connected and how are benefits derived relative to the
5 diagnosis for eligibility for services.

6 But Larry is the expert.

7 DR. LEHMANN: Let me cue off that last bit to
8 point out that OEF/OIF veterans are coming to VA for the
9 range of services, particularly health care services, in a
10 greater proportion than veterans of prior war eras,
11 including Vietnam and even the Persian Gulf War. I think
12 that with regard to mental health, that's certainly true.

13 I think what it speaks to is the results of
14 working against stigma within DOD. The Department of
15 Defense, the Army, and the Marine Corps have never been
16 this open and active in working with mental health issues,
17 and their orientation is very much one associated with
18 recovery and rehabilitation.

19 The Marines, for example, with whom I've been
20 working extensively over the last couple of years, say that
21 the mental and emotional responses to war are an injury
22 like any other injury, and many injuries can have a
23 recovery. You can get over them. They talk about if you
24 sprain your leg, if you break your leg, sometimes a
25 fracture won't heal. Most times it will. So that I think

1 is outstanding.

2 The other thing is specifically about your
3 question about service connection. First of all, the
4 eligibility for VA services for returnees from deployment
5 to the war zone for medical centers is two years after they
6 return from deployment. They can seek cost-free care for
7 things that are related to the war zone deployment for that
8 period of time, and in that time, they can be evaluated to
9 see if they have lingering, longer-term problems that
10 require service connection as opposed to things that can be
11 treated. There is some talk about perhaps extending that
12 to five years.

13 But the important thing to realize is that VA
14 has really two clinical arms for mental health. One is the
15 arm that I represent, the VA medical centers. The other is
16 the Readjustment Counseling Service Vet Centers and
17 Readjustment Counseling Service Vet Centers are open to any
18 war zone veteran without any time limit, without any cost
19 requirements. So people can go there and begin to receive
20 services, begin to be evaluated for benefits, and hook up
21 in that way.

22 Anybody who is service-connected -- we have a
23 priority system. In the example you gave, 10 percent for
24 one thing and 50 percent for another -- if you're 50
25 percent service-connected for anything, you can have

1 services for any problem.

2 So it's a very intricate system. The important
3 thing is for veterans and their families to understand the
4 intricacies of the system so they really understand the
5 benefits that are available to them. There is an 800
6 number on the VA internet website, the www.va.gov, that can
7 help people call in and learn about the benefits that are
8 available to them.

9 DR. CLINE: Ken?

10 MR. STARK: I'm not sure I understood the two-
11 year thing. If I'm a vet and I come back from Iraq and I'm
12 discharged from the military, honorable discharge, and 18
13 months later I start to have some serious, serious symptoms
14 and I go in to get services, did you say I couldn't get
15 services until 24 months after?

16 DR. LEHMANN: No, no, no.

17 MR. STARK: Or I could only get services up to
18 24 months after?

19 DR. LEHMANN: Yes. The two-year window is
20 anytime in that two-year window you can go into any VA
21 medical center with that problem, and you have cost-free
22 medical care for those problems.

23 MR. STARK: What about 25 months later?

24 DR. LEHMANN: Good question and there are two
25 answers. One is you go into any vet center, and I don't

1 care if it's 25 months or 25 years, you can get seen for
2 those services cost-free. That's number one.

3 Number two is --

4 MR. STARK: Before you go to number two, can I
5 ask a question about that?

6 DR. LEHMANN: Yes.

7 MR. STARK: What happens if the nearest vet
8 center is 100 miles away?

9 DR. LEHMANN: Well, there are 150 VA medical
10 centers. There are about 700 community-based outpatient
11 clinics. There are 207 -- going to be soon 230 -- vet
12 centers. They're expanding. So we're trying to make sure
13 that we have some kind of services available within like --
14 it's not 30 minutes. I think it's 30 miles or one hour, or
15 something like that, of location. So trying to increase
16 that kind of accessibility.

17 As far as the current two-year window, number
18 one, the possibility that it may expand to a five-year
19 window.

20 Number two is, quite frankly, if a veteran
21 comes in to us for care and they're in need, most likely
22 what a reasonable medical center staff will do is at the
23 very least find out what's going on with this person and
24 find out what kind of urgent care needs they may or may not
25 have and then work to arrange whatever services they can

1 for them. I think that that's the kind of really
2 practical, putting-the-patient-first orientation that is
3 being supported by the system. They may not be eligible
4 for long-term care at a particular point, but at least just
5 check them out. Find out what's happening. Look to the
6 person and try to help the person is just a basic concept
7 of medical necessity and appropriate care.

8 DR. CLINE: Dr. Lehmann, thank you for the
9 response. I'm going to direct us back to our question and
10 what ideas the council members have in terms of kind of
11 advising the direction for SAMHSA at this time.

12 Barbara?

13 MS. HUFF: Thank you both for an excellent
14 presentation.

15 In response to just a couple of things, just
16 some ideas. Your question was so, I thought, very
17 pertinent about rural communities and where do people in
18 rural communities get care. It seemed to me like there's
19 already an infrastructure in rural communities for
20 community mental health centers. Where you don't have
21 people, Larry, is there a way to beef up what's already
22 there, train up people to work with vets? I'm just saying
23 that because the infrastructure is already there. And get
24 paid, yes, provide extra funds for that through the block
25 grants.

1 DR. LEHMANN: I think that's how we can partner
2 with SAMHSA to try to help. They'd certainly be willing to
3 help out with that.

4 MS. HUFF: You know, like through the block
5 grant. They need to beef up the funding to states,
6 therefore, community mental health centers.

7 DR. CLINE: And I think this is part of where
8 tomorrow morning in our roundtable, part of our discussion,
9 in terms of formulating recommendations to SAMHSA, would be
10 helpful, and if there's a need for that, to be able
11 identify the need for training of local mental health and
12 substance abuse providers especially in rural areas.

13 MS. HUFF: I'd like to address the women's
14 issue part because under you, Kathryn, you're funding the
15 National Child Traumatic Stress Networks.

16 MS. POWER: Yes.

17 MS. HUFF: If you could beef that up. Having
18 been a military family during the Vietnam War, my former
19 husband became an alcoholic, and I don't know if he would
20 have, based on that experience, or not. Having been part
21 of a situation around domestic violence, it seems to me
22 like also then there might be a need to train up around
23 women's services related to that. I hate to say that but
24 it's true.

25 So already existing services to women -- it

1 seems like rather than create more, that there are a lot of
2 really good existing services to women and communities,
3 even the size of Wichita, Kansas where I live, whereby over
4 time we may see more of a need for this as we recognize the
5 co-occurring mental health and substance abuse issues and
6 that sort of thing. So I want to just say that also.

7 Also you have in place the statewide family
8 organizations and other existing support entities that
9 could have a little extra money to beef up some work with
10 military families, and I know on military bases from my own
11 experience there are disability support services. But
12 different than that, more family to family. It doesn't
13 necessarily have to be associated on a military base but
14 just extra support through the statewide family
15 organizations for families who are experiencing difficulty
16 at certain stages. So I wanted to say that.

17 Then just one kind of last thing. I really
18 like the words "psychological health." I think that from
19 our perspective as a military family -- my brother was in
20 the Vietnam War also. Nobody would have ever talked about
21 anybody having any mental health problems, mental illness.

22 But I think the word is so much more acceptable to think
23 about it. As bad as I hate to see -- what Larry was
24 saying, it's true. I'm so glad to see it in some ways,
25 though you hate to think that this war is bringing about a

1 lot more acknowledgement of mental health issues with men
2 and women, but I'm also glad to see it because I think
3 there will be more people trying to access services before
4 things get to a really tragic place, as sometimes they do.

5 So I'm glad there is more of an acceptance, but I think
6 there will be even more of a continued acceptance with the
7 change of that word.

8 I also think that our own experiences -- there
9 were huge, huge issues about not getting mental health
10 services because it would go on your record as such and
11 that was going to be then the real kicker for advancement
12 in the military, as you well know, I'm sure from being in
13 the military yourself. But that's been huge for years in
14 the military culture, and I think anything we can do to
15 continue to try to promote some of that differently would
16 really -- I really was thrilled when you mentioned there's
17 a change there. So thank you for that.

18 I give you total accolades for your work in
19 this because this will be a challenge. I've just lived a
20 little bit of that life for a little while. Thank you.

21 DR. CLINE: Thank you, Barbara.

22 Governor?

23 MR. AIONA: Yes. I really can't speak to
24 what's going on right now in regard to our state. As you
25 know, we have a state in which we have a huge military

1 presence.

2 But I will say this from my own personal
3 experience because I have a security personnel who was
4 deployed to Iraq for about a couple of years. We've been
5 talking about treatment. We've been talking about after.
6 We're not talking about before it happens. Prevention is
7 mentioned up there. Intervention. But I don't think
8 there's anything really substantive going on in regard to
9 prevention and intervention as much as it could have been.
10 The example is simply the guy on my detail.

11 He's 42 years old. He's in the Guard. He had
12 his orders about a year before he was going to actually
13 train for his deployment. Well, he heard. Then he
14 actually got his orders. I think he had a few months to
15 get ready for that.

16 Well, being where we are right now and the
17 previous experiences that we've had with Vietnam, et
18 cetera, I would expect that we could do a better job in
19 prevention and intervention at that point with families
20 especially, people like him. We talk about the Guard.
21 Here's a man that's 42. His children are in high school.
22 He's basically in the twilight of his career in the
23 sheriff's department where he works. And he was just
24 totally traumatized by this whole thing, and you could see
25 it. I didn't have to be an expert to see that he was

1 traumatized by it, and his family was also. But he go no
2 services. There was no intervention. Nothing happened.

3 And so now he's been back for about a couple of
4 years now and he's talking to me in the car while we're
5 going to events and asking me for advice on what's wrong
6 with him. He doesn't want to get any more medication, et
7 cetera. And I look at that and I just scratch my head
8 because I think if we had a good intervention program and a
9 better prevention program for not only him but the family
10 also, I think some of this could have been avoided. Maybe
11 not. I'm not sure.

12 You know, we talk about prevention and we talk
13 about intervention, and I just think that that needs to be
14 a stronger component. I know you got it in there. I just
15 think that we need to really address that. That's
16 something I'm going to bring up also when we talk about --
17 we've got a couple of grants right now that we're working
18 on.

19 But that really just kind of pains me to see
20 that happen, and I know he's not the only one and you all
21 know that too because the Guards and the Reserves are so
22 much a part of it. It just so happens that he was in the
23 war zone. He was part of -- I think they call it executive
24 protection for the various officers in the Green Zone. Is
25 that what it was? I don't know. Something like that.

1 Thank you. I didn't mean to ramble.

2 DR. CLINE: Thank you very much, Governor.

3 We will move to our last comment from Dr. Gary.

4 DR. GARY: Lieutenant Governor, when you were
5 talking and you were giving that example, I just wanted to
6 reemphasize. I think Ken had mentioned it earlier, and
7 that is the issues regarding deployment. What can we do
8 when we anticipate deployment?

9 But we didn't talk enough about reintegration.
10 What can we do with families and communities when the
11 person is going to be returning to the family? If you have
12 a man who has been gone for two years, his wife has managed
13 everything quite okay, I hope, for two years. The children
14 have grown up. They're as big as their father. And it's
15 very difficult for the military person to reintegrate, but
16 it's equally difficult for the wife and the children and
17 the neighbors and the extended family to re-accept and
18 reposition themselves with this person in the household as
19 one of the major players in the household.

20 So I'd just like to reemphasize that that
21 reintegration I think is as important as what we do before
22 the deployment, and maybe it should be a yin/yang
23 situation. It goes together like bread and butter, if you
24 will, and we just don't leave them to chance, that they
25 will be reintegrated, that they will be okay. But I think

1 it has to be a family-focused issue and all family members
2 have to be educated around the essentials for reintegration
3 because it impacts the roles and functions and the
4 attitudes and behaviors of everyone in that family.

5 DR. CLINE: Thank you.

6 As council members, if you have questions or
7 thoughts on this matter or anything else that we've
8 discussed today, we do have some time in the morning for a
9 roundtable discussion, and certainly feel free and you're
10 encouraged to write those comments down to crystalize those
11 and to bring those in the morning. If you'd like those to
12 be on the record, certainly we can do that during that
13 roundtable time, or if you're not concerned about that
14 being on the record, then certainly seek out staff in
15 between the meeting times.

16 But for now, we will move to our public comment
17 time. We have two people are signed up for public comment,
18 and we'll start with Brian Altman. Brian, if you could
19 just identify yourself and the organization you're with.
20 Thank you.

21 MR. ALTMAN: Thank you for this opportunity to
22 address the SAMHSA National Advisory Council. My name is
23 Brian Altman and I am here representing the Suicide
24 Prevention Action Network USA, or SPAN USA, in my capacity
25 as Director of Public Policy and Program Development.

1 SPAN USA is a 501(c)(3) organization dedicated
2 to preventing suicide through public education and
3 awareness, community action, and federal, state, and local
4 grassroots advocacy. SPAN USA is the nation's only suicide
5 prevention organization dedicated to leveraging grassroots
6 support among suicide survivors, those who have lost a
7 loved one to suicide and those who have attempted, and
8 others to advance public policies that help prevent
9 suicide.

10 SPAN USA would like to thank SAMHSA for its
11 strong support of suicide prevention. SAMHSA has provided
12 a pivotal role in the advancement of suicide prevention at
13 the federal level. Among the many activities that SAMHSA
14 has been an integral part of include the formation of the
15 National Suicide Prevention Lifeline, or 800-273-TALK, and
16 the National Action Alliance for Suicide Prevention. In
17 addition, SAMHSA has provided tremendous support for the
18 Garrett Lee Smith Memorial Act grants, including the
19 Suicide Prevention Resource center. Finally, SPAN USA
20 applauds SAMHSA for adding suicide prevention to its
21 matrix. Administrator Cline, former Administrator Curie,
22 as well as Deputy Administrator Broderick and SAMHSA staff,
23 Mark Weber and Richard McKeon, all deserve special thanks
24 for their efforts on these programs.

25 SPAN USA is especially pleased that SAMHSA

1 chose to hold today's National Advisory Council meeting on
2 World Suicide Prevention Day. World Suicide Prevention Day
3 is an annual event sponsored by the International
4 Association for Suicide Prevention in collaboration with
5 the World Health Organization. This year's theme is
6 "Suicide Prevention Across the Lifespan," and SPAN USA's
7 Executive Director, Jerry Reed, wanted to be here.
8 However, he is at the United Nations presenting on the
9 important topic of elderly suicide prevention.

10 So thank you again for SAMHSA's efforts on
11 suicide prevention, and we look forward to continuing to
12 work together on this important public health program.

13 DR. CLINE: Great. Thank you, Brian.

14 The next comment is Judy Cushing.

15 MS. CUSHING: Dr. Cline, do you mind if I come
16 closer?

17 DR. CLINE: Okay. If you could just turn on
18 the microphone there, Judy, and speak into that. Thank
19 you.

20 MS. CUSHING: It's a quiz. Time to wake up.
21 We've got some energy drinks for you. How many of you have
22 heard of energy drinks?

23 (Show of hands.)

24 MS. CUSHING: How many of you have heard of
25 energy drinks containing alcohol?

1 (Show of hands.)

2 MS. CUSHING: How many of you know which is
3 which?

4 (No response.)

5 MS. CUSHING: A new product has entered the
6 scene in the last couple of years and it's getting really
7 scary. Although I came to really talk to you about
8 something else, I'd like to talk to you about the suicide
9 issues that you were hearing about this morning because
10 we're part of that crisis line network and I wanted to
11 commend you on the work you've done to support that network
12 that's absolutely critical, as it is also for veterans. I
13 decided instead, because I came a distance, that I would
14 share with you this emerging product in two minutes or
15 less.

16 A new product has entered the market and it's
17 scary for a lot of people, and it should be scary for all
18 of us. It's called an alcoholic energy drink. Which of
19 these contain alcohol? Can you see them well enough? We
20 have Full Throttle, Sparks, Rockstar, one version, Tilt,
21 Rockstar and Rockstar.

22 There are now 500 energy drinks on the market.
23 Two of these contain alcohol. The industry has done an
24 incredible job of confusing the consumer and, most of all,
25 confusing parents and the adults who interact with kids.

1 We simply have to mobilize people into action in
2 communities to take responsibility for educating the public
3 about this.

4 Years ago, the bartenders started mixing vodka
5 with Red Bull, which is the most popular energy drink, and
6 the industry began to realize there was something to it
7 because it was a hot product in bars. They decided that
8 they would take their very, very popular energy drink
9 market, which is now a \$3.2 billion industry in 2006, and
10 add alcohol to it and come up with clever products packaged
11 similarly to the energy drinks. And who's going to tell
12 except in some states where they can be sold -- they can be
13 sold side by side in some states; in other states, they
14 can't be.

15 Sparks and Tilt. One contains 6 percent
16 alcohol. One contains 8 percent alcohol. The danger here
17 is that the caffeine levels in these drinks is very, very
18 high. In Rockstar, they'll tell you that it's 80 percent
19 caffeine, but this is a double amount. So it's actually
20 160 percent caffeine.

21 When you mix alcohol and caffeine and you drink
22 many of these, because kids think they can and they won't
23 get drunk, trouble. What we're hearing is that emergency
24 rooms are seeing kids who have really gotten themselves
25 into serious consequences by consuming a number at a time.

1 We think this is a travesty, that the industry
2 shouldn't be allowed to package drinks containing alcohol
3 so similarly to drinks not containing alcohol, particularly
4 when we're talking about a product that is so, so popular
5 with our teenagers.

6 The other thing that's confusing for both
7 adults and teens is the fact that these contain things we
8 relate health to, ginseng and ginkgo and other things that
9 we want to put in our bodies to be healthy. So the public
10 is confused. Kids are not because, as Kathleen Sullivan so
11 aptly put it this morning, they're on the internet.
12 They're text messaging. They know where to look for
13 products, where to get products, and how to learn about
14 products. And that's how these products are being
15 marketed. It's called grassroots marketing. They're being
16 marketed over the internet and through text messaging more
17 than anything else. You won't see them advertised nearly
18 as much as you see beer advertised in magazines and on
19 television.

20 I ask you to really consider the wave of this
21 kind of product that's entered the market. We've been
22 successful. Our advocates like Alice Murphy in this room
23 and others around the country have been successful in
24 pulling products like Spikes off the market or getting
25 Anheuser Busch to pull Spikes when the attorneys general

1 came out several months ago. Spikes was the little 2-ounce
2 bottle that was sold in mom and pop grocery stores that
3 contained 12 percent alcohol in wonderful flavors,
4 chocolate and mango, et cetera that kids could pour into
5 their Coca-Cola and spike their soft drink.

6 This is just the beginning. Energy drinks have
7 been on the market a while, but this is the beginning
8 because the energy drink makers, which include Anheuser
9 Busch and Miller and others, realize that this is where the
10 market is going, and it's really hit the soft drink market
11 hard.

12 So it's time for community action, and that's
13 where SAMHSA comes in. We need SAMHSA's help to help
14 communities learn how to advocate pulling products like
15 this off the shelves, how to inform their leaders, how to
16 inform parents and policymakers, and take action to get
17 results.

18 The prevention movement did it with Spikes. We
19 did it with the Macy's T-shirts last fall that were
20 advertising alcohol in their back to school ads. We can do
21 it again, but we need to have SAMHSA's support in training
22 and technical assistance to local community coalitions who
23 are the grassroots movement and can really get the job
24 done.

25 Thank you so much for your time.

1 DR. CLINE: Judy, thank you for the comments.

2 We have one more person who would like to make
3 a comment who had written in requesting to do so. It's Jim
4 McNulty.

5 MR. McNULTY: Thank you, Dr. Cline. I want to
6 thank all the members of the council and the staff. You
7 guys have put in a remarkable day, almost heroic I would
8 say.

9 And I will make my comments as brief as I
10 possibly can. As Kathryn will tell you, however, I can
11 never let a microphone go by without stopping to say
12 something into it.

13 DR. CLINE: Jim, if you could just identify
14 yourself too.

15 MR. McNULTY: I'm sorry. My name is Jim
16 McNulty, and I am the past President of the National
17 Alliance on Mental Illness. I am also currently a member
18 of the CMHS/SAMHSA National Advisory Council. I used to
19 work for Kathryn when she was the Director of the
20 Department of Mental Health, Retardation, and Hospitals in
21 Rhode Island, and I was an advocate before that. Let's
22 see. What else am I doing? I'm running one of your
23 national technical assistance centers, which is funded
24 through the Center for Mental Health Services.

25 And I'm also the chair of something called the

1 Consumer/Survivor Subcommittee which reports to the
2 National Advisory Council. And that's really why I'm here
3 because we had a meeting back in July. It was my first
4 meeting as the chair of this subcommittee, and it was a
5 very interesting and, I think, worthwhile meeting.

6 A couple of things that I would just like to
7 bring to the SAMHSA's council's attention is -- and it was
8 brought up by the previous speaker -- the need for
9 technical assistance. One of the recommendations that we
10 made is that we feel that there is not enough consumer
11 technical assistance. There are five national consumer-run
12 technical assistance centers right now that are funded by
13 the U.S. government. We're not ungrateful for that. What
14 we really would like to recommend is that there be an
15 additional regional technical assistance center in each HHS
16 region, for a total of 10, plus the five national. The
17 need is vast for technical assistance and information and
18 we are less than a tiny drop in the bucket.

19 I'm advocating to you to advocate in your
20 strategic planning process if you would consider focusing
21 on that because one of the things that we find is that
22 technical assistance puts the tools people need to get the
23 job done for themselves. Larry Fricks, for instance, spoke
24 very eloquently about what was happening with peer
25 specialist services. That's a classic example of the kind

1 of technical assistance that we are providing at various
2 different levels and various different aspects. So having
3 said that, I really would encourage the SAMHSA Council to
4 understand the need for that.

5 I'm going to tell a little, very brief
6 anecdote. My wife had to be taken to the emergency room
7 two weeks ago because she had an asthma attack. She also
8 lives with mental illness, as do I, and I also spend a lot
9 of time working with folks in my community with mental
10 illness. Now, my wife was seen within 10 minutes. She was
11 on a stretcher. She was in a room. She was hooked up to
12 all kinds of machinery, and the doctors and nurses were
13 attending to her.

14 I had a similar experience two years before
15 that when I went in complaining of chest pain. A 50-year-
16 old guy walks in an emergency room complaining of chest
17 pain -- believe me, they got you down with nitroglycerine
18 and IV and everything else in no time flat.

19 About six weeks ago, I had the opportunity to
20 take a friend of mine to a hospital emergency room in Rhode
21 Island. He lives with mental illness and that was why he
22 needed to go the emergency room. And he had to wait eight
23 hours before he was even seen. Ultimately he was turned
24 away with no services.

25 So one of the things that we find is that we're

1 funding a perfectly good emergency room program -- it's a
2 pilot program, but I think it should be disseminated --
3 where we put people like me in hospital emergency rooms to
4 talk to consumers and calm them down and work with them and
5 help them. I think that's an example of what the peer
6 specialist programs can do. A very cost effective way, I
7 think, of helping improve mental health services and
8 generally behavioral health services.

9 So I thank you for your attention and good
10 luck.

11 DR. CLINE: Thank you, Jim.

12 We will now move to the last segment of our
13 day's agenda, and that is to recognize several of our
14 retiring council members. I don't know how we'll work the
15 microphones on this, but I think we'll just head over here.

16 I don't know if Ms. Holder is on the line. Okay, we
17 didn't get her. So we'll recognize three of our retiring
18 members: Ms. Dieter and Ms. Huff and Ms. Sullivan. All
19 three of whose terms are expiring.

20 PARTICIPANT: In December.

21 DR. CLINE: In December, right.

22 PARTICIPANT: That means you have to take my
23 calls after that.

24 DR. CLINE: We'll take your calls well after
25 that. Actually you give me a perfect opportunity just to

1 emphasize how valued your input has been.

2 When I came on board, of course, I asked a lot
3 of questions about the council members and the
4 contributions and all those things. I wasn't about to walk
5 in this room without that information and I had
6 conversations with each of you beforehand. So I know it's
7 been not just my experience but the experience of my
8 predecessor, as well as my colleagues. I would hope that
9 that would continue as well, that there is an open door and
10 your participation and your input is valued. I know that
11 that will be true, and I look forward to that in the
12 future.

13 This is just an opportunity for us to actually
14 recognize that contribution officially and through this
15 venue. So I'm going to step over here.

16 MS. VAUGHN: Okay. I'll call your name. Then
17 you'll come up and then Dr. Cline will say a few words.
18 Then we'll take individual pictures and then a group
19 picture.

20 Gwynneth Dieter.

21 (Applause.)

22 DR. CLINE: Just to read this, it says, "I
23 would like to express my sincere appreciation for your
24 service on the Substance Abuse and Mental Health Services
25 Administration National Advisory Council from October 2002

1 through September 2007." That is a long time. "I know
2 from our conversation at lunch, as well as your
3 participation in my initial NAC meeting, that you have
4 contributed significantly, and I only regret that our
5 opportunity to work together on the council has been so
6 limited.

7 "Your strong commitment, knowledge, and
8 leadership in improving the quality and availability of
9 treatment and prevention services for substance abuse and
10 mental health were extremely important in making the
11 council successful in achieving its goals. You and the
12 council have helped SAMHSA achieve its distinctive mission
13 to build resilience and facilitate recovery for people with
14 or at risk for substance abuse and mental health.

15 "Enclosed is a plaque acknowledging SAMHSA's
16 appreciation for your work on the council.

17 "Once again, thank you for your support and
18 advice throughout your term of service. Your
19 recommendations will be helpful in guiding SAMHSA's efforts
20 to ensure life in the community for everyone.

21 "Best regards and good wishes on your
22 endeavors.

23 "Sincerely, Terry Cline, Administrator."

24 (Applause.)

25 MS. VAUGHN: Barbara Huff.

1 (Applause.)

2 DR. CLINE: Paging Barbara Huff. Is there a
3 Barbara Huff in the room? There most certainly is.

4 I'm going to actually read your plaque so
5 people will get a sense of what that says. So this is,
6 "Presented to Barbara Huff with appreciation for your
7 outstanding tenure on the Substance Abuse and Mental Health
8 Services Administration National Advisory Council and
9 gratitude for your tireless support, advice, and insights
10 to the benefit of SAMHSA, the U.S. Department of Health and
11 Human Services, and the people we serve. September 2007."

12 MS. HUFF: Thank you.

13 (Applause.)

14 DR. CLINE: I'll ask each of the retiring
15 council members to make a few words once we have handed out
16 all three. So it will give you a little time to be
17 thinking about your comments to your group. If you thought
18 you were off the hook, you're not.

19 MS. VAUGHN: Kathleen.

20 (Applause.)

21 DR. CLINE: I know we have just a small
22 fraction of your fan club here. Let me read this.
23 "Presented to Kathleen Sullivan with appreciation for your
24 outstanding tenure on the Substance Abuse and Mental Health
25 Services Administration National Advisory Council and

1 gratitude for your tireless support, advice, and insights
2 to the benefit of SAMHSA, the U.S. Department of Health and
3 Human Services, and the people we serve. September 2007."
4 Signed by Terry Cline.

5 MS. SULLIVAN: Thank you, Terry. Thank you
6 very much.

7 (Applause.)

8 MS. VAUGHN: The other member who is retiring
9 is Diane Holder who could not be with us today. So we will
10 be mailing her plaque to her.

11 DR. CLINE: And now to ask each of the retiring
12 council members just to say a few words that you'd like to
13 share, and so it won't be entirely one way, I'm going to
14 ask any council member who would like to respond to those
15 comments to feel free to do so. This is your opportunity.

16 Ms. Dieter, let's start with you, please.

17 MS. DIETER: Well, I'm taken a bit by surprise
18 because I didn't know we would be asked to do this.

19 My time on the council has been just
20 extraordinarily meaningful to me as a person. I was
21 nervous coming on to the council because I came as a mental
22 health advocate from more of the consumer side. I had no
23 professional background in the area. But I found the
24 council members then and the current council members to be
25 so knowledgeable and so open in sharing their expertise and

1 information and not in any way diminutive of me and my lack
2 of knowledge. So I learned a huge amount. It's been
3 fascinating.

4 I was just thinking, my gosh, at my first
5 council meeting, we were talking about co-occurring as a
6 new terminology that needed to go out in that sense. Now,
7 of course, that's widespread and accepted.

8 And today listening, I thought, boy, there has
9 been a great deal of progress with the last report on
10 actually psychological health in the military. This is
11 progress if this happens. As you said, I think it's bound
12 to happen. It's in the works now and it's going to happen
13 finally. And I so agree with Barbara that you never want a
14 war situation or our young people in battle, but if this is
15 one of the benefits, that's a good thing.

16 I suppose also I'm going on too long, but it's
17 kind of emotional. I really enjoy this. Not only have I
18 learned so much, but we're great friends. I think
19 particularly Toian and Kathleen and Barbara and now Ken and
20 Faye and Laurent -- you know, it's just been great. I
21 actually am really confident that we'll remain friends and
22 keep in communication and we'll keep bugging you a little
23 bit to make sure you're doing what we want.

24 Anyway, thank you so much for the privilege.
25 I'm sorry to talk so long. Thank you.

1 DR. CLINE: You're absolutely welcome. Thank
2 you. Any comments for Ms. Dieter?

3 (No response.)

4 MS. HUFF: It's probably just as well I didn't
5 have time to think about this.

6 MS. SULLIVAN: Don't you dare shed a tear.

7 MS. HUFF: Oh, I won't.

8 MS. SULLIVAN: Because you know how I am.

9 MS. HUFF: I know. I gave my tears up with
10 that whole suicide thing that we had to deal with two years
11 ago, whenever that was.

12 It is a good thing I didn't know that I was
13 going to have to say anything because I would have probably
14 planned something long as my last hurrah.

15 I think it was probably the ultimate honor that
16 I had as a parent, as Christie's mother, in being asked to
17 be on this advisory council. All of you know I'm an
18 interior designer. That's where I came from in this. But
19 I think like so many of us who threw up the window and
20 said, I'm mad as hell and I'm not going to take it anymore,
21 and I landed here.

22 But it has taught me a lot. One of the things
23 it's taught me I think, being on the council -- now, I know
24 maybe not all of you, especially Ken, might not agree with
25 this. But I think I've had to be diplomatic. I think I've

1 had to use some level of diplomacy, and I say that
2 seriously because Ken the last time said, Barbara, if you
3 say anything more about those statewide family
4 organizations not having their money. He said, we know, we
5 have heard, and you're just like an ongoing recording about
6 it. So not always am I totally diplomatic.

7 But I think it has taught me a lot about
8 sitting here in a position where you feel like you have a
9 little bit more power than you do in your everyday life as
10 an advocate. But you've got to figure out how to use it
11 diplomatically. I think I've learned that over time.

12 I've made great friends and we've had great
13 audiences of people who have listened to our woes and our
14 battles we have fought for a population that we all are
15 invested in.

16 I have learned way beyond the world of children
17 and families, and that's been a good thing for me. As you
18 well know, I also have tunnel vision there because that's
19 where my heart is.

20 I think I can thank my daughter who is 37 years
21 old now but has been in parts of the system over 30 years.

22 I thank her for allowing her life to be an open book too
23 because that's also allowed me to be, I think, a better
24 council member by being able to utilize my expertise as her
25 mother in this world.

1 And then last, I think I would say that I
2 believe in SAMHSA and I believe in the work they do and I
3 believe in the people that do this work for not always
4 great pay because it is in their heart.

5 I think that I have this wonderful opportunity
6 -- and I said this to Terry -- to be probably the first
7 Democrat in a more Republican political environment to sit
8 on this council. Are you a Democrat, Ken?

9 MR. STARK: Independent.

10 MS. HUFF: So Charlie Curie was, I felt, pretty
11 adventurous actually to allow me to be on this council, the
12 first family member. And I was the Director of the
13 Federation of Families for Children's Mental Health at the
14 time.

15 But I think most important it has boosted up
16 families who have children with mental health problems to
17 have a representative on this council. It has given them
18 much more visibility by having me on the council. However,
19 it's been a huge responsibility to represent them. So I
20 hope I've done it okay, and I just am honored to have been
21 invited and to have had the pleasure of serving those we
22 all care about.

23 Thanks, Terry. Thanks, Toian.

24 DR. CLINE: Thank you.

25 So I'll now turn it over to Ms. Sullivan. Then

1 we'll open up the microphone to the floor.

2 MS. SULLIVAN: Yes, I didn't know either, which
3 is good I guess.

4 When I first came here, the people here know
5 very well, I guess, my story. But basically I was shut
6 down by my family when in the late '90s I was diagnosed
7 bipolar. Well, it should have been no surprise considering
8 my father was institutionalized before I was born and my
9 mother is mentally ill and my grandmother is an alcoholic
10 and I was a beaten child. This is not a new thing. But I
11 still couldn't say it in public. When I did, people were
12 furious. I mean, how dare you even say the word.

13 But when I joined this council, it became okay
14 to be mentally ill. It became okay. Mark knows exactly
15 what I'm thinking of. This is the first time I had a
16 support system.

17 So every time we have a meeting, we talk about
18 support systems. I think about would I have gotten that
19 service. Would I have known about that service? I go to
20 these web pages. How would I get this information?
21 Because I didn't know what was going on.

22 So over the years, this has become a family to
23 me and a support system. And I look at all of you and I
24 hear in the back of my mind a psychiatrist I had in 1998
25 saying, you know, you people with bipolar, you're prone to

1 just cry at an instant just like all those actresses up at
2 the Academy Awards. Mark has heard me say that before.
3 You know, you have all become a family.

4 When I say I'm not leaving, I'm not leaving
5 because you're my family. I'm not leaving. Honestly, I
6 can't say goodbye because I'm not going to go. I mean,
7 I'll be here probably for your meetings. It doesn't matter
8 if I'm on the council or not because I feel I'm a part of
9 SAMHSA, and I am so grateful. It's not only everything you
10 do, but the spirit in which you do it. I've gained, I
11 think, lifetime friendships here on the council and also
12 within SAMHSA. I'm just not going anywhere. So I'm not
13 going to say goodbye.

14 In fact, I know when Jane Maxwell left, I was
15 just so upset because I emailed her all the time. I
16 thought all of us should just go on a retiring advisory
17 council cruise so all of us could just talk about what was
18 the council without us because we all care so much. We
19 talk to each other. I don't feel like I can leave. So I'm
20 always going to be here.

21 So that's it. But thanks for the plaque. I
22 appreciate the plaque.

23 MS. HUFF: You know, Theresa needed a plaque.
24 She left early.

25 MS. VAUGHN: She got one.

1 MS. HUFF: Did she get a plaque? Okay. I just
2 wanted to make sure. She was a good council member.

3 DR. CLINE: Well, thank you all very much for
4 those comments. It's easy to see why each of you have been
5 so treasured. That little bit of stubbornness, I think,
6 has been one of the qualities that you've brought to the
7 table.

8 PARTICIPANT: The three divas.

9 DR. CLINE: The three divas is what I just
10 heard from someone.

11 We'll open it up for comments from council
12 members. Actually I'm going to probably break protocol and
13 open it up to the room as well. Any comments?

14 MS. VAUGHN: I'd like to say one thing. The
15 memory that I will carry with me is my first meeting with
16 all of you, Kathleen and Barbara, in which I had you seated
17 next to one another.

18 PARTICIPANT: Never again.

19 MS. VAUGHN: There was so much energy on one
20 side of the room that I said we need to balance the room.
21 As a result, I consciously placed you -- so that's the
22 memory I will take with me.

23 And Mrs. Dieter, I'll take my love with you.

24 DR. CLINE: Any other comments?

25 MR. AIONA: I just want to say I look forward

1 to these meetings. You are very much diverse in your
2 thoughts and in your work, but you bring a strong voice to
3 the table and we're going to miss that.

4 I'm going to miss it. I think I'm up next year
5 with Ken. Charlie did put together a real diverse group
6 here, and I guess we're the remnants of it. We'll soon be
7 moving on.

8 But you're right about friendship. These are
9 the kinds of things that bring you together. And they're
10 blessings really because it's something that you never
11 dream about. You don't orchestrate it, and it just
12 happens. So I'm going to miss you guys.

13 You know Hawaii is always open to you. You can
14 always come and visit.

15 MS. HUFF: I figured they put me on the council
16 because they were sick and tired of me taking my five
17 minutes at every one of these council meetings.

18 (Laughter.)

19 MS. HUFF: They'll just put me on it and hear
20 from me differently.

21 DR. CLINE: Although it may be a little bit
22 awkward, in terms of the process, each of you is invited to
23 continue to participate until your replacement is appointed
24 and through that process. That's something that we're
25 always a little bit uncertain exactly what the time line

1 may be for that because it's outside of our control. So
2 it's possible that you could be back here in your current
3 capacity. The awkwardness with that comes in not really
4 knowing if it's a final goodbye as a participant in this
5 council. That's why we take that.

6 MS. SULLIVAN: It's just like being in the NFL.

7 DR. CLINE: Exactly.

8 MS. SULLIVAN: You've made the team, you're on
9 waivers, you're cut, you're --

10 DR. CLINE: But you never know until the last
11 minute. The pay is not quite as good, but your
12 participation is valued, as much if not more, as a member
13 of the team. So thank you very much.

14 We will now close. I will ask the retiring
15 members and the council members to go out to the lobby
16 where we will have a picture taken of the small retiring
17 group and then the larger council member group together.

18 So we will now adjourn. Thank you.

19 (Whereupon, at 4:00 p.m., the meeting was
20 recessed, to reconvene at 9:00 a.m. on Tuesday, September
21 11, 2007.)

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24