

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

44TH MEETING
SAMHSA NATIONAL ADVISORY COUNCIL

September 8, 2008

SAMHSA
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TABLE OF CONTENTS

	<u>Page</u>
Consideration of the Minutes from the September 2007 and March 2008 SAMHSA Council Meetings	5
Acting Administrator's Report	9
Update on SAMHSA's Hurricane Emergency Preparedness	22
Update from Council Members	29
Elevating the Role of Behavioral Health in Overall Health: Positioning SAMHSA in a Changing Health Environment	54
Creating and Sustaining Recovery Oriented Systems of Care	125
Update on Legislative Issues	190
Public Comment	198

1 P R O C E E D I N G S (8:00 a.m.)

2 MS. VAUGHN: Good morning. My name is Toian Vaughn
3 and I am the Designated Federal Official for the SAMHSA
4 National Advisory Council. Dr. Broderick, we have a quorum
5 and, as I told you earlier, Dr. Kirk will not be able to join
6 us. SO I will now turn the meeting over to you.

7 DR. BRODERICK: This is the 44th meeting of
8 SAMHSA's National Advisory Council and I would like to
9 welcome each of you. Thank you for taking the time to be
10 with us today. We have a bit of a different type of venue
11 for us to experience over the course of the next couple of
12 days, so I am very excited about seeing how tat unfolds.
13 Gail, thank you so much for all the work you have done in
14 sort of prepping us all for this meeting.

15 Perhaps it would be helpful at this point in time
16 if we would all introduce ourselves to each other and all the
17 people in the audience. So I will start. My name is Rick
18 Broderick and I am the Acting Administrator for SAMHSA.

19 MS. KADE: Hi. I am Daryl Kade. I am the Director
20 of the Office of Policy Planning and Budget, and I am the
21 Executive Director of this Council.

22 MR. STARK: Ken Stark. I am the Director of
23 Snohomish County Human Services in Washington State. I am
24 having trouble with that title. I just changed jobs about
25 six weeks ago.

1 MR. GILBERT: Good morning. I'm George Gilbert. I
2 am the Director of the Office of Program Analysis and
3 Coordination in the Center for Substance Abuse Treatment.

4 MS. WAINSCOTT: I am Cynthia Wainscott from
5 Georgia. I am a mental health advocate, family member, and a
6 new member of this Council.

7 MR. CROSS: Good morning. I am Terry Cross, the
8 Executive Director of the National Indian Child Welfare
9 Association and also a new member of the Council.

10 MS. HARDING: Good morning. I am Fran Harding, the
11 new Director of the Center for Substance Abuse Prevention.

12 MS. CUSHING: Good morning. I'm Judy Cushing. I
13 am President of Oregon Partnership, a statewide nonprofit in
14 Portland, Oregon and member of the Council.

15 DR. WANG: Ed Wang, Director of the Office of
16 Multicultural Affairs, Massachusetts Department of Mental
17 Health. I am also a new member of the Council, and good
18 morning.

19 MS. SPEAR: Hello. I'm Terri Spear, and I am
20 SAMHSA's emergency coordinator, and will be speaking to you
21 of all of the storms that are in the area.

22 MS. HUTCHINGS: Good morning. I am Gail Hutchings.
23 I am President and CEO of Behavioral Health Policy
24 Collaborative, your facilitator for some of the dialogue
25 sessions today and tomorrow morning. I am also former chief

1 of staff of SAMHSA.

2 DR. LEHMANN: Good morning. I am Dr. Larry
3 Lehmann. I am Associate Chief Consultant for Mental Health
4 in the Department of Veterans Affairs, focusing on post
5 deployment disaster response and post traumatic stress
6 disorder.

7 MR. BRAUNSTEIN: Good morning. I am George
8 Braunstein, the Executive Director of Chesterfield Community
9 Services Board in Virginia and a member of the Council.

10 DR. DELANEY: Good morning. I am Pete Delaney. I
11 am the Director of the Office of Applied Studies here at
12 SAMHSA.

13 MR. ALEXANDER: I am Marv Alexander, Vice President
14 of the Youth Move National. I am a new member of the
15 Council.

16 DR. GARY: I am Faye Gary, endowed professor at
17 Case Western Reserve University in the School of Nursing and
18 a member of the Council.

19 MS. POWER: Good morning, everyone. I'm Kathryn
20 Power, the Director of the Center for Mental Health Services
21 here at SAMHSA.

22 DR. HUMPHREYS: Good morning. I am Keith
23 Humphreys. I am a professor of psychiatry at Stanford
24 University School of Medicine.

25 MR. WEBER: Mark Weber, Director of Office

1 Communications here at SAMHSA.

2 MS. ENOMOTO: Kana Enomoto, Acting Deputy
3 Administrator.

4 DR. BRODERICK: We have had a number of new staff,
5 senior staff, join us since the last Council meeting. One
6 just introduced herself. Fran, could I ask you to introduce
7 yourself at a bit more length to the Council? Fran Harding
8 is the new CSAP Director and has been here for a fairly short
9 period of time. I don't know that you know most of these
10 people, so it might be helpful for you to give a little bit
11 of background.

12 MS. HARDING: Good morning again. I hail from New
13 York State, worked there for state government for 26 years in
14 prevention. I was the Associate Commission for Prevention
15 and Recovery Services. I have also been very active at the
16 National Prevention Network, and a period of time had the
17 pleasure of being their president. Nice to see Ken. I
18 haven't seen you in a very long time.

19 Prevention is what I have devoted my professional
20 career to, my children would say I have devoted my life to,
21 but I haven't, they are first. I am very, very pleased and
22 honored to be here, and looking forward to the Council. We
23 had a Prevention Council meeting, and I am interested to see
24 how this Council interacts with the goals and mission of
25 SAMHSA.

1 Thank you.

2 DR. BRODERICK: Thank you, Fran. In addition to
3 Larry from the VA, we have also got representatives from the
4 IHS, FDA and NIAAA with us today. Also, I would like to
5 acknowledge Jerry Reid, Jerry, thank you for joining us
6 today, and Andrew Kessler. Thank you for joining us today,
7 Dr. Kessler. NIMH I think is represented as well.

8 **Agenda Item: Consideration of the Minutes from the**
9 **September 2007 and March 2008 SAMHSA Council Meetings**

10 Before we get going with business, I guess it is
11 business, we need to approve the minutes. Toian has a
12 statement I am supposed to read here verbatim, so if you will
13 bear with me.

14 The September 10 and 11 minutes. These minutes
15 were certified in accordance with the Federal Advisory
16 Committee Act regulations. Members were given the
17 opportunity to review and comment on the draft minutes.
18 Members also received a copy of the certified minutes. If
19 you have any changes or additions, they will be added to this
20 meeting's minutes. If not, can I have a motion to approve
21 the minutes?

22 MS. WAINSCOTT: I so move.

23 DR. GARY: I second.

24 DR. BRODERICK: The minutes have been approved. A
25 motion to approve has been seconded. So moved.

1 For the March 12 meeting minutes. Again, these
2 meeting minutes were certified in accordance with the Federal
3 Advisory Committee Act regulations. Members were given the
4 opportunity to review and comment upon the draft minutes.

5 We received two minor comments which were
6 incorporated into the draft. Members also received a copy of
7 the certified minutes. If you have any changes or additions
8 they will be added in this meeting's minutes. If not, may I
9 have a motion to approve the minutes?

10 DR. GARY: I so move.

11 MS. WAINSCOTT: Second.

12 DR. BRODERICK: The minutes have been approved.
13 Thank you.

14 Before we get started with the administrative
15 report, many of you may be interested in Dr. Cline's
16 whereabouts, status and our transition. So I will spend a
17 few minutes talking to you about that. Faye asked me this
18 morning already, and many of you may be wondering as well.

19 Terry left the Administrator's position officially
20 a week ago Sunday, it was the last pay period in August, and
21 transitioned to a position of health attaché to the U.S.
22 Embassy in Baghdad. I dropped him off at the airport on
23 Friday. He departed for Heathrow I think that evening, and I
24 believe should be in Baghdad tomorrow. He flew through as I
25 said England into Jordan commercial and then will fly by

1 military transport to the Embassy.

2 He will be staying in the green zone, in what he
3 described as a college dorm kind of affair. He took one bag
4 with him about this big, and shipped three boxes of clothes.

5 So there is not a lot of opportunity for personal
6 possessions in this very small quarters that he has.

7 He was very excited to go. Those of you who he
8 talked to may have heard this story, but I will share it with
9 you for those of you who may not know. He was meeting with
10 the Deputy Secretary, it has been several months ago now, I
11 guess. The Deputy Secretary mentioned to him that the then-
12 health attaché was coming to the end of his tour, which ends
13 in mid-September. He said, if you know of anybody who is
14 interested in backfilling behind Dr. Himmler, please let me
15 know. We are looking for someone to take that spot. Terry
16 said -- that was a Friday afternoon, he left that meeting and
17 as he was leaving he said, that is something that I might
18 like to do, to himself.

19 Being a political appointee and coming to an end of
20 a term, he knew that his job would end on the 20th of
21 January, and saw this as an opportunity to play a role in the
22 rebuilding of the health system in Iraq, to include
23 behavioral health services, and thought it over over the
24 weekend and called the Deputy Secretary back that following
25 Monday and said, I'll do it.

1 The line wasn't real long, quite frankly. There
2 wasn't a lot of competition that he had to overcome for that
3 particular position. He has been in training for about a
4 month, I guess, State Department sponsored training for about
5 a month, learning everything from how to drive HUMVEEs to
6 shoot weapons of various kinds to participate in nation
7 building and diplomatic venues across the Mideast.

8 He is in a year-long assignment. The health
9 attache job is a year appointment, and we look forward to
10 hearing from him once he gets established there with a new
11 telephone number and e-mail address. He surrendered his
12 Blackberry to me as he was getting out of the car. Virtually
13 the whole time -- those of you who understand or have
14 encountered the federal IT system, he spent virtually the
15 whole time that we travelled from the Humphrey Building to
16 Dulles Airport fussing with the IT people about what was to
17 happen with his new e-mail account and how he could not fill
18 out a form that was required in three days, at the end of
19 which period of time if the form wasn't filled out, they
20 would cut off his e-mail access. He said, I am only going to
21 be there for three days. So 30 or 40 minutes later there was
22 some brief resolution, an acknowledgement that he needed to
23 have more than three days to get this requisite form filled
24 out.

25 But all to say that he is very excited about the

1 opportunity that presents itself, and we wish him well and
2 wish him safe travels.

3 **Agenda Item: Acting Administrator's Report**

4 With his departure we at SAMHSA started our
5 transition a bit earlier than I had anticipated, although it
6 will be repeated across this Department and across government
7 over the course of the next six months, with the departure of
8 one administration and the election of a new. So there will
9 be many people like the team at SAMHSA here that are career
10 civil servants or in my case, commissioned officers in the
11 Public Health Service, that are charged with stewardship of
12 this organization and all executive branch agencies as well,
13 between the time this administration leaves and the new
14 administration takes place. We anticipate following the
15 election that a Secretary will be appointed sometime in mid
16 to late January, and at that point in time the search for and
17 appointment of the agency level positions, political
18 positions, will occur.

19 Charlie's position with the change between Clinton
20 and Bush administration took about six months. I think
21 Charlie was appointed in June and confirmed in October of
22 November, something like that. So it could take less than
23 that, it could take more than that. Suffice to say that we
24 all are committed here at SAMHSA to be good stewards of the
25 responsibility that has been asked of us, and we will focus

1 on staying the course and making sure the train continues to
2 run on time, and focusing on the policy issues that you all
3 have been so helpful in helping us achieve some clarity and
4 focus on. To that end, I know Gail is going to help lead to
5 a very rich discussion on two of those.

6 The issues to me, just so you will know what my
7 focus is, what I think is important to the extent that that
8 has some bearing on all of this, I would like to talk about a
9 little bit. Before I do that though, I want to introduce
10 Kana Enomoto, who is known to all of you, I'm sure. Kana was
11 named the Acting Deputy Administrator of SAMHSA with Terry's
12 departure and my assumption of the Acting Administrator's
13 role. Thank you, Kana.

14 Kana, would you like to say some things to the
15 folks who may not know about you?

16 MS. ENOMOTO: For those of you who don't know me,
17 my original position is principal senior advisor. I was
18 formerly Special Assistant to Administrator Curie. With Dr.
19 Cline's arrival he asked me to be his principal senior
20 advisor, so I served in that role for the last 18 months, and
21 have had the opportunity to work with Dr. Broderick for some
22 three years. I think we make a very good team in the Office
23 of the Administrator. So I am looking forward to continuing
24 to support him in his new role.

25 DR. BRODERICK: Thank you, Kana. I reflect back

1 when Mr. Curie departed, and I found myself sitting here in
2 the first Council meeting in this chair, now almost two years
3 ago. I learned a lot since then, thanks to all the people in
4 this building and many of you.

5 If I had to identify those things that I would like
6 to talk about and focus on and see what progress could be
7 made over the course of the next year, it is not a real long
8 list, and it has been consistent since I have come here.

9 One has to do with suicide prevention. I am
10 extremely interested in looking for ways to move that effort
11 forward. Kathryn has done wonderful work and the staff at
12 CMHS. Jerry, thank you for all the effort that you have
13 contributed. I think we have made some progress. There is
14 still much that needs to be done to prevent the needless
15 deaths that occur in this country each year.

16 We had a briefing on the national survey last week,
17 in fact, did a press release. There are a number of things
18 that jump out at one, but the two things that jumped out at
19 me are the things that have been most difficult for us to
20 address, or we have not been as successful as we have in
21 other areas.

22 The treatment gap with regards to substance abuse
23 remains unacceptably high. We know that about 20 million
24 people, 95 percent of those people who need treatment, don't
25 think they do and don't get it. That number has remained

1 fairly constant over the course of time. I think it is time
2 that we begin to talk about that, what can be done about it.

3 I don't know that we necessarily have the answers, but it
4 clearly requires collaboration to begin to not only talk
5 about that treatment gap, but to address it.

6 Also, the difficulty in reaching the 18 to 24-year-
7 old age cohort. That number has remained fairly constant as
8 well with regard to their use of alcohol and illicit drugs.
9 I think we need to begin to look at ways to make similar
10 progress that we have with the younger age cohorts to those
11 young adults.

12 I am also interested in the behavioral health needs
13 of veterans. The VA does wonderful work in that regard.
14 Larry, thank you for the partnership around our recent
15 conference on returning vets. DoD clearly has a role. I
16 believe that SAMHSA has a role, as do many of our community
17 based systems, in making sure that the safety net has a very
18 small mesh, and in fact, that the people who find themselves
19 either without services because of the challenges of distance
20 or without services because of eligibility, find those
21 services in ways that are acceptable to them. So the
22 behavioral health needs of veterans clearly is something that
23 we need to continue to focus on.

24 The last one I would mention is my interest in the
25 behavioral health and behavioral health needs of the

1 indigenous people of this nation. Clearly the epidemiology
2 shows the unacceptably high rates of substance abuse and
3 mental health issues in American Indian, Alaskan Native and
4 other indigenous communities in the Pacific. Toward that
5 end, Terry had put requirements in each of the SES
6 performance plans, the Senior Executive Service performance
7 plans, that we visit those communities with greater emphasis
8 this year. In fact, I think the overall target that we had
9 set was 20 visits by executive staff to native communities
10 this year. We have already exceeded that substantially, and
11 I want to thank each of the SES members who have gone out to
12 Indian country, to Alaska and to the Pacific jurisdictions
13 and to the Caribbean into those indigenous communities to
14 better understand and talk to the people who live there about
15 the conditions that they experience and the ways that we may
16 be able to help address their significant needs.

17 We have also embarked on a number of projects
18 internally that Terry has emphasized. One is increased
19 emphasis on process improvement. We recently hired a new
20 senior advisor for process improvement named Bruce Waltuck,
21 and we are focusing on projects to improve the internal
22 processes at SAMHSA.

23 We have also focused on issues to raise the
24 employee morale and the integration of all of us, quite
25 frankly -- it is not just an employee based initiative -- in

1 an initiative called People First. Each year we do a survey
2 across government of about 40 questions that queries people
3 about their job satisfaction and associated issues in the
4 workplace.

5 Two or three years ago and historically, federal
6 employees aren't a terribly happy lot with their jobs, but
7 suffice to say, SAMHSA was not high on the list of -- or was
8 among the unhappy. So Terry asked Kana to lead an initiative
9 called People First that has focused over the course of the
10 past year or so on addressing many of those issues. We have
11 got a system in place that works on a variety of issues that
12 were noted in the employee survey that was one.

13 We all participate, the executive staff, the
14 management staff, union staff, non-union staff. It is a
15 SAMHSA effort, it is not an employee driven effort. We have
16 seen considerable progress over the course of the past year
17 from two surveys ago to the last survey in 39 of those
18 questions, significant improvement in each of those areas.

19 There is still much to be done. I don't think it
20 would be fair to say that now everybody is just thrilled every
21 day they walk in the door, but suffice to say that the trend
22 is in the right direction, and we will continue our emphasis
23 in that area.

24 Not necessarily related to that, but one of the
25 issues that has come up that might help employee job

1 satisfaction is the opportunity to do other things, do other
2 things in the workplace. I have asked some of our executive
3 staff to do that as well.

4 Some of you may have heard that all of our deputies
5 at the centers are on assignment in other places. I want to
6 thank them for the great work that they are doing in those
7 new assignments. At the Center for Mental Health Services,
8 Kathryn's deputy is Ted Searle. Ted is now serving as Wesley
9 Park's deputy at CSAT. In his place Dr. Anna Marsh is
10 serving as Kathryn's deputy. Rich Kopanda for a time left
11 the CSAT deputy's position and is acting as Fran's deputy in
12 CSAP. Dennis Romera left CSAP and is serving as the deputy
13 executive officer in the Office of Program Services under
14 Elaine Perry.

15 So you can see that there has been some movement of
16 our executive staff. They are contributing new perspectives,
17 excellent ideas in those locations, and I am very pleased at
18 how it is going so far. The details were for 120 days. They
19 will be up I think the first of October-ish, and we will at
20 that point evaluate whether they need to continue for a bit
21 or when they will return. They are not permanent
22 reassignments. I anticipate that they will return to their
23 positions of record. It is just whether it will be the first
24 of October or a little bit longer. We will all have a chance
25 to talk about that.

1 Another one that I would mention, a sharing
2 opportunity, is Dr. Larke Huang. Many of you know Larke as
3 the senior advisor for Children and Families Behavioral
4 Health in the administrator's office. Larke will be going to
5 the Centers for Disease Control as our liaison there. She
6 will maintain her position here as well. It will be a short
7 term six-month detail to CDC.

8 We met with Dr. Gerberding and her senior staff a
9 couple of months ago. One of the results of that meeting was
10 a request by CDC to assign a senior staff member to them to
11 help them learn more about behavioral health and what SAMHSA
12 does. Larke is wonderfully positioned to do that. She is
13 very excited about the opportunity, and she will be in
14 Atlanta virtually full time. She will be back here every
15 several weeks to maintain her portfolio of responsibility
16 here as well, but by and large spend most of her time in
17 Atlanta in that liaison role.

18 We expect much good to come from it. In fact, we
19 have talked about with CDC the opportunity for when Larke
20 returns to have others perhaps go to CDC, as well as have CDC
21 staff come here. I think that that partnership reflects very
22 well the need to integrate public health concepts, public
23 health principles, into the behavioral health field.

24 So with those job sharing opportunities, it wasn't
25 done because of People First, but suffice to say that our

1 senior executives are walking the walk and are experiencing
2 opportunities to contribute in different ways for short
3 periods of time.

4 At this point in time I would like to talk a little
5 bit about the new format that we are trying during this
6 venue. Gail has I'm sure contacted each one of you and
7 interviewed you about two issues that she is going to lead us
8 in a discussion of over the course of the next few hours. It
9 will provide the Advisory Committee an opportunity to have a
10 conversation if you will about these two issues, and help
11 inform our thoughts about them and about how we find the way
12 forward with regard to those two issues.

13 We also have an opportunity to hear from Terri
14 Spears about some of the storms that are buffeting the
15 Southeast part of this country. I had the opportunity to
16 travel with Secretary Leavitt last week to Texas and to
17 Louisiana in the wake of Hurricane Gustav. It was very clear
18 that the nation is much better prepared than we were when
19 Katrina struck New Orleans three years ago. The number of
20 people in place, the efficiency of the operations of the
21 shelters, the transport of goods and people. There were two
22 million people more or less evacuated from Louisiana and the
23 Gulf Coast in a very short period of time, either close to or
24 at some distance from their homes.

25 As I saw some of these shelters, my thoughts

1 harkened back to the Metrodome or whatever it is called in
2 New Orleans and the disaster that that was. There is nothing
3 like that now. The three years have been used to good
4 advantage to help us learn about what needs to be done to
5 support people in times of that type of crisis.

6 The two things I was struck with, and the things
7 that challenged the folks in the New Orleans and Baton Rouge
8 area, was the fact that the power grid was disrupted
9 significantly. Virtually the whole state of Louisiana was
10 without power for I'm not sure how many days, I'm sure Terry
11 will tell us, a week anyway. The hurricane didn't just hit
12 and blow through, it just stayed, and it was just kind of
13 there. It was raining and windy and it make it difficult to
14 repair power lines.

15 The hospitals that initially didn't need to
16 evacuate because of the availability of generator power over
17 the course of time found that their generators were not
18 sufficient to carry the load for days and days and days and
19 days and days. They became very hot places.

20 We visited a hospital in Baton Rouge that was under
21 emergency power, the patients were all still there, the staff
22 was still there, but it was probably 95 degrees in the
23 building, and that percentage humidity as well. It was an
24 uncomfortable place to be. This was five days out from the
25 storm's arrival, so they were at that point beginning to

1 evacuate people because their generators were not sufficient.

2 The other thing that I think we need to talk about
3 as an outcome of this recent experience is that there were
4 shelters that were run by various organizations or
5 responsible parties, some locally, some federally, and some
6 were established to provide care to those with an acuity need
7 that was similar to -- would find someone in a hospital.
8 Others were stepdown units, for lack of a better term; people
9 were not sick enough to be in a community shelter but -- sick
10 enough that they couldn't be in a community shelter, but not
11 sick enough to be in a hospital setting. Oftentimes they
12 were nursing home patients.

13 Then there were community shelters for people who
14 weren't sick. The workload in those various places was not
15 equal. Some of the stepdown units that I visited were well
16 staffed. The census was well below capacity, and the staff
17 to resident ratio was quite high. Some of the hospital
18 acuity type places, that was not the case. They were at or
19 exceeding their capacity and the staff were challenged to
20 keep pace.

21 Some of these places were blocks apart. The people
22 who staffed them, while they came from different places, were
23 of similar training. So it seems to me we ought to be able
24 to look at the triage methods used as well as the assignment
25 of staff and the ability to be more flexible and more nimble

1 in terms of moving staff to where the people and the needs
2 are.

3 But other than those two observations, and I'm sure
4 others who spent more time there will have more, it clearly
5 was a much improved process, and the citizens of Louisiana
6 fared much better in terms of what was provided to those in
7 need.

8 The issues that I am going to ask Gail to talk
9 about here very shortly, after Terri shares some information
10 about the storm, have to do with the vision for the future of
11 behavioral health, realistic ways of achieving that vision
12 over the next five to ten years, and specifically the role in
13 elevating behavioral health in overall health systems.

14 It is very clear to me that without an integrated
15 system, without a system where we have public health
16 principles at play, we intervene earlier and behavioral
17 health issues are part of the health system in general, we
18 will continue to have difficulties in addressing the
19 behavioral health needs of this nation.

20 It was kind of interesting; as I was leaving the
21 house this morning, my wife said, so what are you going to do
22 today? I said, I am going to a meeting. She said, what is
23 it about? I told her about the Council and she said, what
24 are you going to be talking about? I said, we are going to
25 talk about the need to integrate public health principles

1 into the behavioral health system and integrate behavioral
2 health care into the larger health system.

3 I explained to her the focus of the behavioral
4 health system over the course of time and its focus on end
5 stage disease, if you will, people who are already in the
6 throes of addiction, people who are already alcoholic, people
7 who are already mentally ill, and the difficulty we have had
8 in moving upstream in that course of disease.

9 She said, how in the heck could you possibly
10 address the needs of an addict before they are addicted? She
11 said, you would need to deal with poverty, you would need to
12 deal with education, you would need to deal with jobs. You
13 would need to deal with all that stuff. How can SAMHSA do
14 that?

15 The answer is, we can't. She is a nurse and has
16 dealt with those issues in a hospital setting for much of her
17 professional career, but it didn't take her very long to
18 figure out that it is something that can't be done by SAMHSA,
19 can't be done by any of us alone. It needs to be
20 integration. It is the notion of integration that we
21 absolutely must, absolutely must, to make progress, make sure
22 that behavioral health issues are part of the larger health
23 system.

24 We cannot, I don't believe, spend our way to
25 health. We spend double the amount per capita as the nearest

1 nation expends on health care, and in spite of that level of
2 spending, we are 24th in the world with regard to health
3 status. If we doubled our expenditures we couldn't spend our
4 way to be the healthiest nation.

5 Part of the reason is, I believe, that behavioral
6 health is not integrated. We do focus much of our attention,
7 much of our effort, much of our resources, on end stage
8 disease, and that needs to change. Gail is going to help us
9 talk about that. The other issue she is going to help us
10 talk about is creating and sustaining recovery oriented
11 systems of care.

12 So that is the opportunity that we have got. It is
13 a little bit different venue. Before we go further though, I
14 would like to have Terri talk a little bit about what we know
15 about the four hurricanes that, to use Secretary Leavitt's
16 term, are lined up like a conga line in the Caribbean waiting
17 to buffet the Southeast part of this country.

18 Terri?

19 **Agenda Item: Update on SAMHSA's Hurricane**
20 **Emergency Preparedness**

21 MS. SPEAR: Good morning. As we have entered into
22 this morning's activities, many of the storms that were in
23 that conga line has now passed over and are now back out to
24 sea. So that is some really good news. The damage that was
25 left behind in many of them were not what was anticipated

1 prior to their landfalls and their progress through this
2 country.

3 But I want to talk to you for just a few minutes
4 about the infrastructure changes. They have told me I can
5 talk to you for ten minutes, so I am going to give you a
6 brief introduction to some of the changes that have
7 underpinned the improvements that Dr. Broderick described
8 seeing in Louisiana as time went by.

9 One of the most recent changes that have occurred
10 in the national platform under which response occurs was the
11 institution and the release of the National Response
12 Framework. This document did not create a great deal of
13 exposure and excitement throughout the emergency management
14 world, and perhaps not in the world that you find yourselves
15 in on a daily basis. However, it has started a huge change
16 in emergency response. What it attempted to do was to
17 reflect the lessons learned from all of the previous
18 disasters that had occurred since 1997 when the national
19 response plan was reviewed.

20 The system is set up very much like the national
21 response plan, with emergency support functions. Behavioral
22 health, both substance abuse and mental health, fall under
23 two categories within that system, both under ESF 6, which
24 has to do with mass care, and ESF 8, which is public health
25 and medical. As you can see, it is one of the many features

1 that exist and are focused on.

2 Many state and local organizations are also
3 organized in the exact same framework that folds into this
4 framework, so that functions are the basis of the
5 organization, so many of your states will have identical
6 ESFs.

7 Most of our activity is conducted under ESF 8, and
8 that is coordinated under the Health and Human Services
9 Secretary's operations center. We maintain 24/7 contact with
10 the operations center as evidenced by the 2:35 a.m. call and
11 the 5:15 a.m. call I received this morning.

12 ESF 8 was changed in April of 2008. This was
13 driven by SAMHSA. We are really proud of the change that
14 occurred in ESF 8. It was changed to state for the very
15 first time to reflect the integration of behavioral health
16 into medical and public health. The exact phrase that exists
17 up here for your reading is also included now in the National
18 Response Framework. This opens the door for many discussions
19 on emergency preparedness and meeting the behavioral health
20 needs of victims from disasters in ways that we are only
21 beginning now to see unfold.

22 It states that public health and medical services
23 include responding to needs associated with mental health,
24 behavioral health and substance abuse considerations of
25 incident victims and response workers. As such, it was in

1 the very beginning of the ESF 8, so every time those terms
2 are included opens the door for behavioral health.

3 One of the other issues that also occurred in the
4 National Response Framework was a flip-flop of focus on
5 response. It flips it from a federal perspective to being a
6 state and local response with primacy.

7 The second thing that has changed recently is the
8 National Incident Management System. It was released in
9 2004. What that is, is a consistent nationwide approach for
10 all levels of government, that is, state, local and federal,
11 to work effectively and efficiently together to prepare and
12 respond to domestic incidents. It consists of a core set of
13 concepts, principles and terminology for incident command and
14 multi-agency coordination.

15 What is really new in 2008 -- you say, but that is
16 four years ago that this happened, but what has really
17 changed in 2008 is the implementation of NIMS. Now proven
18 compliance is a condition for receiving preparedness dollars,
19 so we are seeing a greater implementation of this framework
20 which has been in existence for 30 years, throughout the
21 entire framework.

22 SAMHSA participates on all planning, communication
23 and coordination efforts through a virtual operations center.
24 It is called WebEOC. We respond to all calls, all planning
25 activities that go on.

1 What has changed from previous disasters is this
2 framework under which all requests are delivered. In the
3 past, SAMHSA has received requests of local needs and
4 information, and then we worked very hard to insure that
5 those needs were met. However, that oftentimes left us with
6 not the best in coordination and control at the state and
7 local level, so this is the pathway that is now used. We are
8 working to insure that our partners and all of our
9 constituents are aware of what this pathway is, so that their
10 needs can be met.

11 So now when we receive a call, we instruct them on
12 the pathway and connect them with the resources through their
13 local communities, but now the local need is expressed to the
14 state emergency management agency. If they are unable to
15 meet the need, it then goes to the incident response
16 coordination team. If they are unable to meet the need, it
17 then goes on to the Secretary's operations center, and SAMHSA
18 is involved at that point. Things that are delivered from us
19 then goes back through that exact same framework, so that all
20 parties are aware of what is occurring throughout the
21 disaster.

22 Again, I was told I was given ten minutes to talk
23 with you, so now I will talk to you about what is occurring
24 now.

25 As all of you are aware, Gustav came ashore

1 approximately a week ago. It is now no longer being tracked
2 by any of the OPDIVS. ESF 8 closed out last Saturday, and
3 mobilization is the key focus of the activities that are
4 underway.

5 However, there is a great deal of activity that
6 remains in the state of Louisiana. All of our NDMS teams,
7 DMAT teams, all of our federal medical shelters continue to
8 be operational in the state of Louisiana. Other resources
9 that have been applied for the use of that storm have been
10 sent back to their centers to be restocked and reinventoried
11 for release for Ike.

12 Hannah. Hannah came through, and luckily the
13 damage that resulted from Hannah is minimal, not to the
14 individuals that have suffered from the flooding and the wind
15 damage, however. The states have all indicated that there is
16 no need for federal assistance.

17 Keep in mind, that does not mean that there was not
18 damage. What it means is that the state has the capability
19 to meet the needs of their citizens and are not requesting
20 any assistance from the federal government at this time. The
21 primary if you can remember from the National Response
22 Framework is in the states. As states are able to meet the
23 needs, there is less and less request for federal help.

24 Now Ike, let's move down to Ike. Ike is
25 anticipated to be a major storm. The state of Florida

1 received a pre landfall declaration early yesterday
2 afternoon. It is currently a CAT 2 storm, which means that
3 it has maximum winds of -- as of eight a.m. they were 100
4 miles an hour; by five a.m. they had hit 105.

5 It is anticipated that the storm will weaken as it
6 passes over Central Cuba before entering the Gulf of Mexico
7 by late Tuesday. We are all working off of prediction models
8 that NOAA provides for us, and their accuracy is very good.
9 However, we are now talking of a U.S. landfall outside of
10 five days. Their accuracy decreases as the time the distance
11 goes between them.

12 Currently Ike is anticipated to strengthen as it
13 passes through the Gulf of Mexico, at which time we are
14 anticipating that landfall will occur within Texas, right at
15 the Texas-Louisiana border, late Friday night, early Saturday
16 morning.

17 The activity that it is undergoing now has to do
18 with the pre positioning of personnel, staff, materials,
19 pharmaceuticals and the like in a safe area around the
20 destination or the anticipated landfall site. As many of you
21 might realize, that is being compounded by the re-entry
22 issues, because that is the exact same area that Gustav just
23 went through. So the Department is very active now in trying
24 to monitor the use of resources in those areas and maximizing
25 the efficiency of those activities.

1 Currently we have 20 percent of our commissioned
2 core officers are deployed in preparation and response to
3 Gustav and Ike, and we are supporting those individuals as
4 they are going out.

5 That concludes my three-point activity. I have
6 provided for you reference documents. These are substantive
7 documents. I could clearly say that collection of all of
8 those elements include about 500 pages of direction and
9 guidance on all things having to do with all hazards
10 preparedness. Should you wish to look at them, those are
11 links to those documents.

12 DR. BRODERICK: Thank you, Terri. I would like to
13 acknowledge the wonderful work that Terri does and Matthew
14 Eunace's division in CMHS. They are very busy people
15 ordinarily, but in these times they become doubly so.

16 When I was in Louisiana and Texas over the Labor
17 Day weekend, suffice to say that the Secretary was saying
18 what about this, what about that. I was on the phone trying
19 to figure out the answers to what about this, what about
20 that. Terri and Ann's shop were on it. Suffice to say, the
21 answers were coming back to my Blackberry. I don't know how
22 people quite frankly dealt with that kind of stuff before
23 that technology was available, but I want to publicly thank
24 both Terri and Kathryn for responding quite quickly to the
25 many questions that come up during that venue and for the

1 great work that they do.

2 **Agenda Item: Update from Council Members**

3 At this point, we have got some time set aside for
4 updates from each of you. If you have any questions of me,
5 if you have any questions for Terri about the storms or if
6 you would like to take two or three minutes to let us know
7 what you have been up to since the last Council meeting, we
8 would love to hear from you.

9 So if we can start with you, Ken. You talked a
10 little bit about what is up with you, the commute from South
11 King County to Snohomish County as a change for you. But
12 please proceed.

13 MR. STARK: Thank you. For those of you who don't
14 know, I did shift positions. Almost three years I was the
15 Director of the Mental Health Transformation Project in the
16 Office of the Governor in Washington State. About six weeks
17 ago I changed positions, went to work for the Snohomish
18 County Executive as the Director of Human Services. That
19 means I am commuting one hour north instead of one hour south
20 to get to work.

21 With that said, let me jump into a couple of
22 things. I know we are time short.

23 Probably the biggest thing hitting Washington State
24 and Snohomish County is a more generic issue; it is the
25 economy. Since we are a state that is based on sales tax, we

1 pretty much depend on government revenues, local government
2 revenues, at the state level and at the county level, with
3 people spending money. When people aren't spending money our
4 economy goes downhill. So the state is facing a significant
5 multi-billion dollar shortfall.

6 Many of the counties are in trouble with their
7 local dollars because of housing starts down and of course
8 property taxes and that sort of thing, which helps support
9 local governments. In Snohomish County, we are looking at a
10 nine million dollar shortfall. It is a lot less than some of
11 the other counties. Snohomish County for those of you who
12 don't know it is the third largest county in Washington
13 State. With that shortfall we are clearly having to look at
14 a phase one reduction in force with employees, and we are
15 very much nervous about the phase two impact that will hit us
16 next year when the state budget is finalized through the
17 legislative processes, and also worried about any impacts
18 that will hit us probably next year with the federal budget.
19 So we are bracing for that.

20 From a service standpoint, I think we all know that
21 it is incredibly challenging to serve individuals at the
22 local level when many of those individuals have serious
23 challenges going on relative to a lack of health care because
24 of a lack of health insurance. They have difficulties with
25 transportation, they obviously have difficulties with

1 alcoholism, drug addiction, mental health, a number of other
2 local issues going on, and personal issues going on with
3 them.

4 Trying to get services is always a challenge,
5 because as you talked about, Dr. Broderick, it is very much a
6 silo'd system, and those challenges around engagement and
7 those challenges around transportation very much affect the
8 individual's ability and the provider's ability to come
9 together if there are multiple issues going on.

10 The health care system pretty much does a shoddy
11 job in terms of screening for mental health and for
12 alcohol/drugs, and the alcohol/drug system and the mental
13 health system do a pretty shoddy job of paying attention to
14 the health issues outside of alcohol/drugs or mental health.

15 So we kind of need to come together and start looking at the
16 folks that we are serving in a more comprehensive way, and
17 figure out how we can begin to work together across systems.

18 I also just cringe every time, and people on this
19 Council have heard me say this before, when we continue to
20 use the term behavioral health. When we do that, we
21 stigmatize ourselves on the alcohol/drug and the mental
22 health side, and we separate ourselves outside of the health
23 care system. I very much encourage us to stop doing that,
24 because we are part of the health system. The more we keep
25 using the term behavioral health, the more we separate

1 ourselves from that system. So I really, really encourage us
2 to stop doing that. When I think of behavioral health, I
3 think of heart disease, I think of obesity, I think of all
4 kinds of different things.

5 I am done. I just got carded.

6 DR. BRODERICK: Thanks, Ken. Cynthia?

7 MS. WAINSCOTT: Almost two years ago in Georgia,
8 January '07, a front-page headline shocked everybody: 115
9 suspicious deaths in the state hospitals over a three-year
10 period. We used to judge how much attention we were getting
11 by how many front-page stories we were getting. They were
12 averaging about once a month. They are now about once a week
13 above the fold. I brought one along for you. Georgia's care
14 for mentally ill unravels. That pretty well says it.

15 We got a commission. They were appointed and it
16 met two times without a consumer on it. After very concerted
17 advocacy, a consumer was added and the discussion changed
18 somewhat.

19 Our child and adolescent system is in extreme
20 crisis. Our Department of Human Resources has instituted fee
21 for service; in a state with over eight million people, they
22 served less than 20,000 kids last year. The Department of
23 Community Health, which is our Medicaid agency, has
24 instituted managed care. To say that services are inadequate
25 does not even begin to cover it.

1 As a result of this, our state hospitals have got
2 overcrowding and management issues and funding issues. Our
3 state hospitals fell further into crisis. Remember, almost
4 two years ago this came to the public. We now have a
5 Department of Justice investigation. We don't know how that
6 is going to work out. Kathryn, I am interested to talk to
7 you some at the break about that. Clearly there is a desire
8 by the state government for it to go away. We hope
9 desperately that it will not.

10 A recent Centers for Medicare and Medicaid Services
11 audit said that in our largest state hospital, consumers,
12 patients, were in quote immediate danger. Deaths continue to
13 occur. In the face of that we have just been ordered to take
14 a six percent funding cut. We are fighting very, very hard
15 to hold mental health harmless, don't know if we will be
16 successful.

17 One good piece of news that has come out of all of
18 this is that a reorganization has just been ordered by the
19 governor. He has pulled what he is calling behavioral health
20 department -- and I, Ken, totally agree with what you said;
21 we have to pay close attention to our language. We often
22 hurt ourselves with it. But he is going to create a
23 Department of Behavioral Health and pull out from this huge
24 Department of Human Resources agency that includes child
25 welfare, that includes public health, mental health and what

1 we call addictive diseases. We think that is positive.

2 We had advocated, we the advocates, have advocated
3 strongly to put public health with it. We lost that one, as
4 we expected to, but at least we are going to be out of the
5 morass now.

6 A couple of good things are happening in the state
7 after all that bad news. I am sometimes accused of being a
8 Pollyanna, so I always have to tell you the good stuff, too.

9 We have got a wonderful peer specialist program that is
10 being replicated around the country. Sadly it is being hurt
11 by some of the budget cuts, but we believe that will come
12 back.

13 We have a model access line, it is called. 300,000
14 people called it last year. It came into a single point of
15 entry into our system. It was able to negotiate needed
16 services rather than the person fitting the box that the
17 services existed.

18 Two things on the national level I want to tell you
19 about. One is the National Council on Disability, of which I
20 am a member, has written 146 reports in their history. Five
21 of them have been about mental health. The fifth one I am
22 very proud of. It has just come out. It is on, Dr.
23 Broderick, veterans' health, with an emphasis on PTSD and
24 traumatic brain injury.

25 We have just agreed in our last budget cycle that

1 in 2010 we will have a major mental health report that will
2 be the major report we will put out that year. So I am
3 delighted about that. And it will include substance use.

4 In Mental Health America, another hat that I wear,
5 I am very proud of our work in Partnership to Fight Chronic
6 Disease. There is some information about that in one of the
7 slide shows you got from David Schern, the CEO there.

8 I have served on that Institute of Medicine
9 committee, and I think it is almost five years ago now that
10 it released the report, Improving the Quality of Health Care
11 for Mental and Substance Use Conditions. After looking at
12 that very hard for two years with them, I look at a lot of
13 things through that lens. Dr. Broderick, the things that you
14 listed, suicide, the treatment gap, vets, much of the fix for
15 that comes through integration.

16 Thanks.

17 DR. BRODERICK: Thank you, Cynthia. Terry?

18 MR. CROSS: Thank you. Just a couple of things to
19 mention. I just recently was able to review a copy of Holly
20 Ecklehock's study on tribal financing, that deals with
21 sustainability and financing in systems of care communities.

22 It is an excellent piece of work. I want to commend CMHS in
23 sponsoring that work, but it really points up some very
24 important issues.

25 Three things about sustainability in tribal

1 communities, the importance of what is broadly referred to as
2 sovereignty, the policy level decision making of the tribal
3 government to deliver a set of services, and to deal with the
4 issues at hand. The infrastructure to be able to do that in
5 the broadest sense of infrastructure, not just mental health
6 services, but the ability to manage financially, to be able
7 to bill for services, to become approved as mental health
8 service providers, recognizing several of the issues that are
9 attached to that. And workforce capacity. I hope I haven't
10 stolen Holly's thunder, but I was just so impressed with the
11 work that she has done.

12 The good news is that systems of care impact all of
13 those things in a very positive way. So I think to share in
14 the notion of good news, the work of systems of care about of
15 CMHS is having a positive impact in each of those areas, and
16 there is evaluation data to show that, so very important.

17 Also, it helps us on an advocacy level, as we are
18 making decisions, communications with regard to policy issues
19 in organizations like the National Congress of American
20 Indians and its Policy Research Center, to be able to speak
21 with tribal leaders about these issues, and building the
22 kinds of capacity that it takes, and to show that that is
23 directly linked with the well-being of their children and
24 families.

25 So again, thank you to SAMHSA for this work.

1 I think the other important piece of information is
2 tribal access to Title 4E, the Social Security Act money that
3 reimburses states for the cost of poor children in the foster
4 care system. The House of Representatives passed by
5 unanimous consent some reforms to that piece of law, and
6 included in that tribal access to that so the tribes would be
7 able to run their own services. Also funding for kinship
8 care as well as for children aging out of the foster care
9 system, allowing states into a program of serving children
10 from 18 to 24, I believe. So a number of important reforms
11 in child welfare.

12 The Senate is expected to mark up a similar bill
13 this week, and it is also expected to pass by unanimous
14 consent. Whether they will get all of this work done by the
15 end of the session is anybody's guess. But another important
16 recognition by the Congress of tribes' role in taking care of
17 children and families.

18 DR. BRODERICK: Thank you, Terry. Judy?

19 MS. CUSHING: Thank you. A couple of quick things.
20 You may have seen headline news in the last few weeks about
21 an initiative led by a former college president of Middlebury
22 College to lower the drinking age, an initiative by college
23 presidents. More than 100 presidents have signed on to that
24 initiative, not only to lower the drinking age, but to spark
25 a national discussion around lowering the drinking age.

1 Unfortunately, we think that is a disaster. The
2 prevention approach across the country is rising up to
3 mobilize their constituents, community leaders, and reaching
4 out to college presidents, the thousands of college
5 presidents that haven't signed on to the initiative. But
6 with half a million injuries occurring on campuses each year
7 from rape and falls and alcohol poisoning, along with the
8 level of binge drinking that is reaching very scary
9 proportions. One study 40 percent of college students say
10 they have binge drink and they consider themselves on the
11 road to either dependence or having a serious problem with
12 alcohol abuse, we really do not believe it is wise to make
13 alcohol legally available to 18, 19 and 20-year-olds on
14 college campuses.

15 Of course, this does reduce the liability for
16 college presidents and people realize that. But we think
17 there are more sound reasonable approaches that college
18 presidents and systems can take to address alcohol problems
19 on college campuses, and urge them to do so. They really
20 have come to a very dangerous conclusion, and it is up to the
21 prevention community and the health systems within
22 communities to help educate college presidents about that.

23 We would urge SAMHSA to support the coalitions and
24 your constituents who are working on underage drinking issues
25 to become as well informed with talking points and making the

1 case as SAMHSA can. Both the National Highway Traffic Safety
2 administration and other organizations including MADD have
3 come up with talking points that individuals can use. So we
4 just need to educate folks.

5 The other issue for us quickly was alluded to
6 earlier in your comments, Dr. Broderick. I know that Kathryn
7 is really looking at this daily. That is the problem of
8 suicide among our military, returning soldiers in particular.

9 In our state, 3500 young men and women, some
10 middle-aged men and women, will be deployed, a lot for the
11 second and some for the third time after the first of the
12 year, some beginning in January.

13 The Oregon military has reached out to us as just
14 one organization to try to help them prepare families, their
15 soldiers and help create a safety net as you said, Dr.
16 Broderick, on the front end. We know we are going to be
17 dealing with it on the back end, because we are the lifeline
18 partner in Oregon. But this is obviously happening across
19 the country. Our fear is that our systems aren't nimble
20 enough, do not have the capacity at this point in time to be
21 able to fully support those individuals who are coming back
22 with some very, very difficult problems, and the impact it
23 has on their families.

24 So I think it is something that perhaps this
25 Advisory Council could look at and learn more about and try

1 to become proactive.

2 DR. BRODERICK: Thank you, Judy. Ed?

3 DR. WANG: Similar to what previous members have
4 said, in terms of the challenges, poverty and violence are on
5 the rise. I don't think that is necessarily unique just for
6 Massachusetts, but I think that is a nationwide trend.

7 Individual, family and community protective
8 factors, we can call it maybe safety factors, are losing
9 ground specifically for mental health, substance abuse.
10 These societal contextual determinants have absolute impact
11 in terms of the overall health of our citizens or individuals
12 in Massachusetts and I guess across the country.

13 I don't want to be too Pollyanna, With challenges
14 there are opportunities. This is the part what is facing
15 Massachusetts. We are going through a major system
16 transformation for both adult and children in Massachusetts.
17 We are in the process of transforming our systems and also
18 in terms of service procurement, creating new models,
19 purchasing methods as well as performance measures.

20 For children and adolescents, as some of you know
21 or all of you know, that is sparked by the Medicaid lawsuit.

22 But on top of that is the commitment of our Governor Patrick
23 in terms of creating very much of an integrated system of
24 care that was mentioned earlier in terms of education,
25 juvenile justice, child welfare as well as mental health as

1 well as health as well. So that is the driver or the urgency
2 in terms of children and adolescents mental health.

3 One of the key focus, and also in my work, my focus
4 is in regard to the reduction of disparities, how do you
5 reduce barriers in terms of accessibility as well as
6 increasing the quality of care for culturally diverse
7 populations.

8 This is a critical area, has full support and
9 championed by our Secretary of the Executive Office of Health
10 and Human Services, Dr. Bickby. I think that we have worked
11 together very closely at the state level as well as the
12 national level.

13 I have to give credit to SAMHSA in terms of some of
14 your commitment, in terms of eliminating disparities.
15 Kathryn Power, CMHS, Gary Browe, his work with system of
16 care, Larke Huang works for the entire SAMHSA.

17 The reason for that is, I think there is a lot of
18 knowledge between national and state in terms of knowledge
19 sharing as well as technical assistance. I think that is
20 important in terms of the whole idea about eliminating
21 disparities.

22 The other piece is that we are selected to be part
23 of the Policy Academy for the 16 to 25. That is another age
24 group as mentioned earlier that is really critical to look at
25 what type of needs they have and what type of services that

1 are appropriate for that age group.

2 I think some of the knowledge sharing as well as
3 technical assistance -- I have to say that right now in
4 Massachusetts we are using a logic model of mental health
5 service planning, defining, planning and implementing and
6 measuring in terms of what exactly we are talking about in
7 terms of disparities in Massachusetts, then utilizing the
8 cultural competence section plans that we have done now for
9 several years, as well as the logic model as a way to look at
10 system and service delivery infrastructure, as well as
11 service domains that ultimately affect our populations.

12 Thank you.

13 DR. BRODERICK: Thank you, Ed. Larry?

14 DR. LEHMANN: Thank you. The first thing I want to
15 say is how appreciative we are at having been able to
16 participate in the returning veterans conference. It was a
17 terrific opportunity, not just for us to talk about what VA
18 can do and how VA might be able to help the providers in the
19 states, but also to see what the states are doing themselves.

20 This is really terrific. These nine states and one
21 territory have done a lot of things on their own
22 independently to create the support structures for returning
23 veterans and their families. It was really remarkable and
24 terrific to see how they were learning from each other in the
25 course of the Policy Academy and the meeting. That was

1 really great.

2 A few things that we are doing in VA, speaking
3 about integration of health care. As we speak we are rolling
4 out primary care post deployment health clinics, which one of
5 the models happens to be in the Seattle and Puget Sound VA
6 Medical Center, where the primary care folks are being funded
7 by our primary care division and the mental health services
8 are going to be provided on site in primary care settings by
9 the serving returning veterans mental health teams that we
10 have been standing up across the country since 2005. We are
11 extremely pleased about that.

12 With regard to suicide prevention, again an area
13 where we have gotten tremendous help from SAMHSA in setting
14 up the suicide prevention hot line. One of the initiatives
15 that we had recently, if any of you see in our Metro system
16 or on some of the Metro buses in D.C., these posters that
17 reach out to veterans saying, if you are a veteran or if you
18 know a veteran who is in crisis, call 1-800-273-TALK, and
19 push number one for the specially created dialogue for
20 supporting veterans.

21 What we found during the period of that campaign is
22 that there has been a statistically significant increase in
23 the number of calls to the hot line for veterans in these
24 area codes since those public service announcements have gone
25 out, in speaking to Rich McKeen from SAMHSA who has been a

1 tremendous help to us. This is the first time we have been
2 able to have a documentation about how an approach like that
3 has enhanced the number of people reaching out for care and
4 help. So we are extremely pleased about that.

5 The last thing I will say is that we are also
6 pleased to be able to collaborate in a number of the
7 interagency mental health disaster response programs. Terri
8 of course is participating in those as well.

9 So again, a number of things that we are doing both
10 within VA and collaboratively with our colleagues in SAMHSA
11 and in the communities and increasingly so. So we are very
12 pleased about the opportunity to have those collaborations.

13 DR. BRODERICK: Thank you, Larry. George?

14 MR. BRAUNSTEIN: I am struck by the various
15 priorities and issues that everyone has brought up. I'll
16 just give you a Virginia example of both state and local, and
17 try to make a point out of this.

18 At the same time that we are facing five, ten and
19 15 percent cuts in areas coming from the state, and we are
20 also dealing with local decrease in property tax and dealing
21 with some major cuts, as much as ten percent from the local,
22 we are moving forward with final stages of purchasing and
23 implementing an electronic medical record. We have managed,
24 despite not getting major grant funding, to maintain an
25 excellent program for Housing First for homeless. We are

1 moving forward with instances where we are increasing the
2 integration of all of our child services, including all the
3 juvenile justice system services.

4 I am bringing that point up to suggest that -- not
5 to downplay the fact that there are going to be some major
6 cuts and/or reshifting of funding priorities. I haven't even
7 spoken about the temporary reprieve that we got regarding
8 CMS, because we think that is still coming down the line,
9 where there will be some major changes in how Medicaid is
10 funded.

11 But I would like to bring up the fact that when I
12 talked to the Commissioner on Friday about how to deal with
13 the system that will get probably multi-million dollar cuts
14 in the state of Virginia, my comments to him are that we need
15 to be better focused. We need to be clear what our
16 priorities are and we need to be clear about the strategies
17 we are going to use to insure that those priorities are
18 implemented.

19 So I guess bottom line here is that as I listen to
20 the struggles and the victories that people are having, I
21 think that that is going to become a premium nationwide, but
22 it is floating up from the local areas that way.

23 DR. BRODERICK: Thank you, George. Marvin?

24 MR. ALEXANDER: I have been in transition a lot, so
25 I don't know where I am at, what I am doing. I am joking.

1 At the local level, there has been a lot with
2 systems of care. Our community has rallied around that whole
3 vision of the community coming together to meet the unique
4 needs of young people and their families.

5 One of the things that our state has done, they
6 have taken the charge of creating statewide systems of care
7 for children and young people. It is involving players that
8 we never thought would be involved, the higher education
9 field. We are able to teach courses on system of care, which
10 includes Family Voice and Youth Voice. Also, working with
11 the Clinton School for Public Service in the state to look at
12 system of care efforts and go and evaluate parts of the state
13 where we want to implement the work of system of care.

14 Our transition is from being a clinician in a
15 treatment foster care program to this new exciting role in
16 the juvenile detention center. We are setting the stage
17 through system of care for some major reform not only in the
18 mental health system, but also in the justice system and in
19 the education system. So we see this real spillover of the
20 transformation that was sparked by the grant that SAMHSA gave
21 to the state, and also the TA that is provided through the
22 various contractors.

23 Nationally we have Youth Move National, which is
24 also another organization that is through the system of care
25 looking at young peoples' voice, giving young people a voice

1 in these issues. A lot of times we continue to meet, come to
2 the table, and discuss issues that are of particular
3 importance to young people, but as Cynthia said there was no
4 consumers at the table. In the same token there is no young
5 people at the table, so we are trying to model that for local
6 communities at the state level, able to have young people
7 involved, and through Youth Move National.

8 I am hear representing Youth Move National as well
9 as other young people who have mental health issues or in the
10 juvenile justice special education systems. So there are
11 issues we are bringing to the table as a voice for young
12 people. Even statewide we are starting to look at
13 development of chapters in each state where we can support
14 that voice and further it.

15 Some of those issues in Arkansas or even locally or
16 nationally doesn't always get a lot of play, doesn't always
17 get a seat at the table. So hopefully young people could
18 bring that voice and some new vision, not saying vision isn't
19 already at the table and there is a lot of wisdom and
20 expertise, but also new vision.

21 One of the things that I have taken on as a
22 personal issue, a topic to discuss is the abuse of
23 psychotropic drugs. I think there is something that SAMHSA
24 would probably want to look at, especially among young people
25 who would take their drugs to school, their psychotropic

1 drugs, sell it to their peers. So it has really become an
2 issue. The things that are prescribed to help are actually
3 hurting our communities, and doing some education about that.

4 DR. BRODERICK: Thanks, Marvin. Faye?

5 DR. GARY: Thank you very much. Once again I am
6 appreciative of the opportunity of being here and being a
7 part of this very rich dialogue.

8 I guess I can best describe some of the things I
9 have been doing by just sharing with you some of the
10 experiences that I have had with children in the public
11 school system. I think the public school system is a
12 wonderful venue to be in contact and have sustaining
13 relationships with children. I would suggest that we take a
14 look at that setting and how we can impact the lives of
15 children who are in school, and those who have been in school
16 but who dropped out of school.

17 I go to the public schools and I do what is called
18 the lunch lesson. I take doctoral students with me so that
19 they can have some experiences in working with children who
20 many times present with hopelessness and a sense of
21 helplessness.

22 This particular day, I had prepared a quick lecture
23 that happens during the noon hour called Three Bad Cats in
24 the Neighborhood. I was going to talk about drugs, alcohol
25 and sex. So I went to the board and I started my little

1 prepared lecture, and one of the students said, Oh, Miss
2 Faye, there are more than three bad cats in the neighborhood,
3 there are a whole lot of bad cats in the neighborhood. So I
4 asked them to tell me what the bad cats were in their
5 neighborhood. It is drugs, alcohol, violence, poverty,
6 unemployment, uninformed parents, disconnected parents,
7 poverty, et cetera.

8 So when I listened to these children tell me about
9 what they were facing, it immediately reminded me as you have
10 just said about what is going on in Boston. If you look at
11 the social determinants of health, as your wife pointed out
12 this morning, Dr. Broderick, we know that we have to find a
13 way to collaborate with all of the NIH groups, with
14 foundations, churches and whatever.

15 What these children did is, they defined these
16 social determinants of health. It was amazing to me. They
17 were just on target. The schools don't have all of the
18 resources that are needed to address these issues, but I
19 think some way that we at SAMHSA and other NIH organizations,
20 agencies and institutes can begin to look at what is facing
21 these children.

22 In my group, I had a young man who was huge. He
23 said, Miss Faye, I cry every day. Every day I cry. He said,
24 I am depressed all of the time. Other children described
25 that they have difficulty with their impulse control. That

1 is aggression. They give up. They drop out of school, and
2 they drop out of school with no resources, poor families,
3 more crime, drug selling, and they try to survive in a way
4 that they possibly can.

5 I am also struck by the fact that when we try to
6 get help for children and adolescents, it is just so limited.

7 I can spend all day or all week trying to find an inpatient
8 facility to try to place a child in. They just don't exist.

9 They don't make money. Inpatient child psychiatry services
10 don't make money, and they don't exist and literally don't
11 exist, especially for poor children.

12 So I think we need to look at the prevention. We
13 need to look upstream and see who is pushing people in the
14 stream, and we also have to look at those individuals who are
15 downstream who are drowning, and we have to try to find a way
16 to help them, especially if they are children and
17 adolescents.

18 I also am working with a Head Start group in
19 Florida and in Cleveland. What the Head Start directors tell
20 me that there are three or four-year-old children manifesting
21 disruptive behaviors, to the extent that they have to refer
22 these children for professional services. They cannot be
23 maintained in the Head Start program. So if we know that
24 that is occurring, then I think we have to look
25 programmatically not only at the social determinants of

1 health, but what our priorities are and how we focus our
2 activities and our energies around some comprehensive health
3 care for children and families.

4 I also just want to point out to you that there is
5 a new report from the World Health Organization. It came out
6 last week. It is on the Internet. The whole report is about
7 250 pages, but the executive summary is about 35.

8 They make three basic comments about improving the
9 health of people in the world. The first one is to improve
10 the conditions under which people live, especially children.

11 That is exactly what I learned from Three Bad Cats in the
12 Neighborhood.

13 The other is the provision of health services and
14 the redistribution of power, wealth and intellectual
15 resources. The third one is some way to evaluate the
16 outcomes of programs and to assure that there is a competent
17 diverse workforce. These are some of the same issues that I
18 think we struggle with, but I think we need to give them some
19 more attention as we grapple with how we are going to look at
20 recovery and how are we going to do the transformation in
21 mental health and substance abuse.

22 From a national level, I serve on an NIH road map
23 subcommittee, where we are looking at health disparities and
24 how is it that we as a nation can better address the
25 elimination and reduction of health disparities.

1 I would also like to tell you that I teach a course
2 in ethics at the detention center in Florida, which is my
3 home state. At the detention center when I teach the course
4 in ethics, I tend to begin with the basic ethical principles
5 of respect and justice. The children there love to talk
6 about justice, but when I talk about beneficence, it is a
7 different issue, because they have not developed the capacity
8 to have empathy for others to the extent that I think they
9 should.

10 Thank you.

11 DR. BRODERICK: Thank you, Faye. Keith?

12 DR. HUMPHREYS: The most important thing that is
13 happening in mental health care in California is in the
14 prison system, which now has more mentally ill people and
15 addicted people than all our health facilities put together.
16

17 The last five or ten years, a series of inspectors,
18 of whom I was one, went through various facilities and
19 reported to the governor, the legislature or both about the
20 appalling state of all health care, not just mental health
21 care. Systems now under the control of a federal Special
22 Master with incredibly broad powers, in fact, more powerful
23 than both the governor and the state legislature, has already
24 put several billion dollars into hiring health professionals.

25 The interesting thing about it will be that it is a

1 Constitutional case, so one of the outcomes will be a
2 statement on what level of health care including mental
3 health care is considered Constitutional as a basic right. I
4 am curious to see what that is, and also curious to see if it
5 ends up that prisoners have a higher right than what many
6 uninsured people in California who are not in prison get.

7 In terms of what I have been doing personally in
8 mental health, mostly it has been involvement with Iraq. I
9 have to say, SAMHSA under the leadership of Admiral Broderick
10 and Dr. Cline and before that Charlie Curie, has done more
11 for the Iraq mental health system than any agency in HHS.

12 I went to Iraq in April. I have been teaching over
13 there. There was very enthusiastic reception from across the
14 country. Iraqis have great interest in finding out what is
15 happening in mental health while they were shut off from the
16 rest of the world. SAMHSA very wonderfully sponsored a large
17 number of teams to come over here and work at different top
18 institutions in the universities, including here in Johns
19 Hopkins right here in Washington. That was a great
20 experience. More teams are coming over this fall, and we
21 expect to go back to Iraq either this fall or this spring.
22 So I do want to applaud the agency for that. It has been a
23 remarkable inspiring effort.

24 There are many stories I could tell; for time's
25 sake I won't. But among the striking things was, a friend of

1 mine from Baghdad, seeing the poorest neighborhoods of
2 Baltimore and saying I am glad I can raise my kinds n Baghdad
3 because this looks pretty hard here.

4 DR. BRODERICK: Thank you. We have come to the
5 appointed hour for a short break. Before I do that though, I
6 want to inform you, I am going to be gone for about an hour
7 after lunch. At that point I will ask Kana to chair the
8 meeting. My boss says he needs me for a bit. I didn't
9 expect that to happen today. Be that as it may, let's take a
10 ten-minute break, and then we will come back and, Gail, we
11 can begin our conversation.

12 Thank you.

13 (Brief recess.)

14 **Agenda Item: Elevating the Role of Behavioral**
15 **Health in Overall Health: Positioning SAMHSA in a Changing**
16 **Health Environment**

17 DR. BRODERICK: It is my pleasure to introduce Gail
18 Hutchings. I think Gail is known to many of you. She is a
19 former SAMHSA employee, acting Deputy Administrator, Acting
20 Chief of Staff, Senior Advisor to the Administrator, Acting
21 Director of the Center for Mental Health Services. She is
22 now the president -- as she said when she introduced herself
23 and failed to mention those other things -- the president of
24 Behavioral Health Policy Collaborative.

25 Anyway, as I said earlier, Gail agreed to help us

1 today and facilitate a conversation on two points. She
2 interviewed all of us and will synthesize over the course of
3 this morning what we all had to say about those two
4 particular topics, and help us have a conversation about
5 them. So Gail, I will just turn it over to you.

6 MS. HUTCHINGS: Good morning. Thanks very much for
7 inviting me here. My apologies in advance to the audience.
8 My back will probably be to you much of the time. Some
9 people think it is my better side. So my apologies.

10 A pleasure to see all of you, some old colleagues
11 here. We are here for a very serious discussion, but I
12 thought we would start with a little bit of levity this
13 morning. There is lots of response that shows that humor is
14 a way to spark creativity and investment and hopefully to get
15 your focused on why we are here.

16 So let me start by saying yes, Rick is absolutely
17 right, I was at SAMHSA for quite awhile. I had a lot of
18 different roles. Between the two of us we could probably
19 have our own thespian troupe with all our acting roles. I
20 had a great time while I was there. You might recognize
21 yourself in a couple of these slides. This is a little quick
22 pictorial of some of my recent career moves that may be of
23 interest to you. When I was at SAMHSA, I prided myself with
24 many of my colleagues, as hopefully being among the people
25 that asked some of the tough questions. I think a lot of

1 them certainly did that.

2 But there did come a time for me to leave. I
3 thought really long and hard what is the best thing for me to
4 do, where shall I go, what was a way to apply my skills, some
5 midlife career change, if you will. Lo and behold, I thought
6 with some of the workforce issues that we are facing, maybe I
7 had some skills so I wouldn't have too rough a time trying to
8 find that out.

9 I did find the perfect job for myself. I finally
10 had to figure out what that is, and did a lot of analysis
11 with skills matching, all those important things that Beltway
12 Bandits do to help us figure that out. But there wasn't a
13 lot of call for queens, so I decided -- not at least that get
14 paid -- so I decided it was the time to go back. You may
15 recognize yourself in this portrait of what happens when you
16 are a self starter.

17 So I regrouped again and decided it was time to
18 think about what I could do where I could make all of the
19 really important decisions all by myself, and all those
20 perks. So there are perks, like working from home in my home
21 office. Here is a picture of what I probably look like when
22 I was doing the phone interviews with you. But the best part
23 of all is that I now get paid to surround myself with very
24 smart people such as you, ask you what you think, then I tell
25 you back what I heard from you and then I go to work. So I

1 really appreciate again the chance to be here.

2 So let's start this dialogue. We are here, all
3 humor aside, to talk about real people with very pressing,
4 serious needs, SAMHSA's role in meeting those needs, SAMHSA's
5 evolving role in meeting those needs. I heard from Dr. Cline
6 and then Dr. Broderick about what some of the vision was for
7 this conversation. We are looking for all of you to help
8 create that vision for what the future of -- and we will talk
9 about terminology -- behavioral health issues. I'll try to
10 do a good job. I actually do believe in using that term, but
11 I'll try to do a better job about using mental health and
12 substance abuse or addictions prevention. I'll try to watch
13 myself. What are some of the realistic ways of achieving
14 this vision over the next five or ten years, Rick had
15 mentioned these, and ways of working internally within
16 SAMHSA, externally with SAMHSA's partners, and then among the
17 field itself.

18 We are again looking for your input to get there.
19 The product will be a summary report that I will work on with
20 the help of Irene, thank goodness, the writer that is here
21 today. That report will come back to you in the form of a
22 product.

23 This is a process review for all of you are
24 familiar, who participated in this. I had the pleasure of
25 these phone interviews with you. They lasted approximately

1 30 to 45 minutes each. You were sent the questions in
2 advance. We discussed about the two key themes we would talk
3 about today. You were asked if you had any suggestions for
4 materials. I presented that whole list to key SAMHSA staff,
5 and you were sent that set of materials in advance.

6 How did you find those? Interesting, not
7 interesting?

8 PARTICIPANT: Provocative.

9 MS. HUTCHINGS: Provocative, good, excellent. We
10 also talked about your recommendations for potential
11 discussants. Many of you had great ideas for folks that
12 could be provocateurs, discussants. After further thought,
13 given how close this meeting was coming datewise, SAMHSA
14 decided that it was better to put those as a future
15 possibility list. So that whole list will be maintained.

16 I will ask for a few ground rules, if we could, to
17 help frame our conversation today. My job is to try to keep
18 us on task and on time, so I ask for your help in doing that.

19 If one person could speak at a time, either raise your hand
20 or put your microphone light on, I will be able to see you
21 and be able to select you. Please avoid speech giving to the
22 extent that you can. You are all brilliant people, as
23 evidenced by your roles and your accomplishments. We are
24 here to try to keep a lively conversation going, so the more
25 active listening I get and the more head bobbing I get, it is

1 probably my respectful way to ask you to sum up the point
2 that you are making.

3 Finally, we will use a parking lot for issues you
4 might raise that it may be better off to raise during another
5 segment of our conversation down the road a bit this morning
6 or this afternoon, so I will write some of those issues in
7 the parking lot.

8 Okay? Ground rules, nothing I don't think everyone
9 can't agree to? Good.

10 We have our share of definitions and usage issues
11 in our field. Ken had raised already this morning behavioral
12 health, mental health or substance abuse, mental health and
13 addictions. We are going to try to use those. We
14 respectfully need to connote some of the fields together when
15 we are talking about that, some of the issues together.

16 Substance abuse to discuss people either in
17 recovery or that have an addictive disorder. Co-occurring
18 disorders, we will use that term. Some of you might prefer
19 MICA or dually diagnosed. Feel free to use whatever you are
20 comfortable with using, but just make sure we all understand
21 what that is.

22 Ready to get started with the first dialogue?
23 Great.

24 Again, here is the framework that we talked about a
25 few times. Tab G in your binder has some of the background

1 materials on this. Let's start with the very first one.
2 These were the materials that were sent you in advance
3 specific to this dialogue, the role of behavioral health and
4 overall health. Note, please, that doesn't say overall
5 health care, it says overall health.

6 Dr. Broderick and Kana are particularly interested
7 in making sure that we have an elementary macro level
8 dialogue that talks about health systems broadly. Make sure
9 there is room for prevention in these conversations, lots of
10 context, how do we keep a healthier nation, healthiest nation
11 if you use the CDC language about that.

12 Many of you have already remarked this morning
13 about integration. We know for this first conversation,
14 elevating the role of behavioral health and overall health.
15 Positioning SAMHSA in a changing health environment that
16 integration needs to be.

17 I think to a person in the interviews, all of you
18 mentioned how important it was to talk about integration,
19 integrating mental health and substance abuse services in
20 overall health, leveraging non-traditional partners, key
21 financing levers.

22 So focusing on this first one, here are three
23 selected quotes from my interviews with you. There is no
24 attribution that was given. We must shift to a public health
25 approach model, concerned and focused on wellness. We have

1 got to use this as an opportunity to move substance abuse and
2 mental health prevention on the public discourse on health
3 system. What is the role of consumers, youth and families in
4 helping position SAMHSA?

5 So enough of my talking. Your thoughts on this
6 issue? Elevating the role of behavioral health, mental
7 health, substance abuse in overall health. Feel free to
8 repeat some of the things we talked about during your
9 interviews.

10 DR. HUMPHREYS: I would say one of the most
11 important things is to accentuate those aspects of our field
12 that are useful for management of other chronic illnesses
13 like diabetes, overweight, cardiac disease and that sort of
14 thing. The technology that we have developed, things like
15 behavior change and teaching people skills and motivation and
16 relapse prevention are all relevant to the health conditions
17 that are first off destroying peoples' health, but also
18 killing the health care system with added costs.

19 If you want to have a partnership with health care,
20 to come forward and say, I have an agenda and I want you to
21 put some resources towards it, not much will happen. But if
22 you say, I have a set of skills, knowledge, expertise that
23 can help you do your job better, then you are more likely to
24 get a good discussion going.

25 MS. HUTCHINGS: So it is an idea not only about

1 what we are asking of other partners and systems, but what we
2 can export to be of assistance and bring to that partnership.

3 Excellent.

4 MS. WAINSCOTT: I think my agenda is pretty
5 aggressive. I don't want to cooperate with the rest of
6 health. I want to be part of it. That is the reality, that
7 is the fact. People who have strokes have depression at a
8 predictable rate. We take care of the quote physical
9 symptoms, -- and I think we have to stop calling them that,
10 we have to start calling them general medical symptoms -- and
11 we ignore the mental health symptoms.

12 So I think the challenge is not so much to
13 cooperate as to become part of. I think it is us become part
14 of them, not them become part of us. It would be a lot
15 easier to do it the other way around, and there are a few
16 places in Georgia now, interestingly in free clinics, where
17 they start out as mental health and occasionally substance
18 abuse clinics, but almost always mental health by themselves,
19 and they are pulling in general medical care. You very
20 rarely see it done the other way.

21 MS. POWER: My vision is prompted by the fact that
22 if you looked at the issue of modern health care, a couple of
23 weeks ago when they listed the 100 most important people in
24 the United States for health care, and mental health and
25 substance abuse were not there at all. So everybody they

1 pictured was somebody related to the private sector or
2 government or elected officials. Nobody was there that
3 represented the addictions field or the mental illness field.

4 So for me, the vision is that we will finally and
5 forever adopt the IOM clinical definition of mental and
6 substance use conditions, and get over everything else, that
7 we will finally adopt that. The vision becomes one of the
8 leadership of mental and substance use conditions being right
9 at the same table with all the other aspects of health care.

10 That is the vision. That means that we have to do something
11 about cultivating that leadership in this five-year period.
12 That to me is the singular most important thing that SAMHSA
13 can do.

14 MS. HUTCHINGS: Leadership, excellent.

15 DR. BRODERICK: I think one of the very first
16 things, before we can help the health system at large or be
17 part of that system, is information and access. We have the
18 general practice to preach to the choir, and we need to find
19 opportunities to inform.

20 What you said is absolutely true. Chronic diseases
21 don't occur -- people are very untidy. They have a lot of
22 things going on within themselves, and chronic diseases don't
23 occur in an organ system. People have multiple chronic
24 disease. We know that if you find one, you are likely to
25 find others. I don't know that that is widely known.

1 I saw something recently about what it would take -
2 - and I think it gets to Keith's statement -- what it would
3 take in terms of time for a teacher to do all the things that
4 others want he or she to do in the course of a day besides
5 teach, or a primary care provider that others want them to
6 screen for or do in the course of a 15-minute visit. Clearly
7 in both of those things there is not enough time in the day
8 to do all of them.

9 So how can we change the standard of care for a
10 physician to include integration of mental health and
11 substance abuse screening, or for a specialty physician to
12 ask questions about a person's mental health status or their
13 substance use? How do we engage that system? The first
14 thing is, we have got to be talking to them. There needs to
15 be an opportunity for information sharing, and then we can
16 get to, and what can we do for you, and how do we all sit at
17 the same table.

18 So I think that a very first part of moving toward
19 the vision that Kathryn stated is to start talking to those
20 who are not in the choir now.

21 MS. HUTCHINGS: So here are some nice relationships
22 being built on peoples' visions of creating these
23 opportunities, coming to them with leadership and then making
24 sure part of the dialogue, Keith's point, is what we have to
25 offer, too.

1 MS. WAINSCOTT: Just briefly, if you think about
2 how America responds to postpartum depression now as opposed
3 to how they did 20 years ago, two things had to happen to
4 change that. People the public, had to understand that
5 after every tenth birth, the mother has a depression severe
6 enough that it needs treatment. We have got that one down
7 pretty much. People understand it. When I go to public
8 places and talk about postpartum depression, the men in the
9 audience are doing this. That was just unheard of 20 years
10 ago.

11 The second thing that has to happen is, payment
12 systems have to change so that doctors are incentivized to
13 find it. We haven't done that one yet.

14 MS. HUTCHINGS: Can I ask you to put those two in a
15 vision statement then?

16 MS. WAINSCOTT: People will understand the
17 connection -- it is what Dr. Broderick said, really -- the
18 connection between chronic conditions, is where you start
19 probably, chronic conditions and mental health needs, and
20 payment systems that don't discriminate.

21 MR. STARK: I think from my perspective, the
22 financing scheme is to me the most critical. Currently most
23 of our financing schemes are very, very fragmented, they are
24 very silo'd. Even on the public sector side we don't have a
25 mental health system, we have a system for mental illness.

1 On the alcohol/drug side in many states you do have some
2 money for prevention and some money for addiction treatment,
3 but not a lot of money in between for folks who may have a
4 serious substance abuse problem but not necessarily
5 addiction, and they are also past the point of needing
6 primary prevention. So there is a gap there

7 On the health care side, depending upon what state
8 you are in, you have got financing that may be available. If
9 you are on TANF, you may get health care, or you will. If
10 you are aged, blind, disabled in terms of the disability
11 group you may get health care. If you don't meet those
12 criteria but you are poor and you still have maybe an
13 addiction, you may not have any health care at all.

14 So my vision is that we have a seamless financing
15 scheme so that individuals who actually need services can get
16 those services in a health care arena, where hopefully we see
17 co-located services at a minimum.

18 DR. GARY: I think my vision is related to the
19 article that you gave us to read by John Carter. The first
20 thing that he says you have to do right is, you have to
21 create a sense of urgency. So my vision is related to
22 creating a sense of urgency about the need to improve mental
23 illness and substance abuse disorders, prevention and
24 treatment. I think once we have that sense of urgency, we
25 can look at the financial system of the context. We can also

1 look at how people are trained, because we are going to have
2 to deal with how we train professionals to do the is. We are
3 going to also have to look at consumers, who we call
4 consumers, and issues of self management. That is another
5 concept that I would suggest that we add. The majority of the
6 time that an individual with any illness survives and lives
7 is outside of the presence of a health professional, so we
8 have to do a better job of self management.

9 MS. HUTCHINGS: I saw a lot of heads nodding about
10 the sense of urgency. I have heard from others, that has
11 resonated with you quite a bit as a group.

12 DR. LEHMANN: Prior to 1989 and the Loma Prieta
13 earthquake, in the disaster health field, if you looked at
14 virtually any book on disaster preparedness you would see a
15 300-page book and one paragraph at the end of one of the
16 chapters on mental health.

17 Looking at this from my own VA part of the
18 elephant, this change at Loma Prieta, when Secretary
19 Durwinsky said we have got to send some mental health
20 personnel out into this area to support the survivors and
21 support the care providers. Increasingly in these series of
22 natural and manmade disasters that our nation has
23 experienced, the concept of looking at the mental and
24 behavioral health aspects has increased and become really
25 something that is accepted and understood by the service

1 providers, and also to an extent by the people, by the
2 community.

3 So I think that the issue of public education as
4 the groundwork for public health, just as we have with
5 smoking, just as we have with seatbelts, is something that is
6 very, very important. It is important to train all health
7 care providers to accept the fact that mental health care is
8 a part of all health care, one of the key tenets of the
9 President's new Freedom Commission.

10 But I think you are right about self management.
11 We also have to teach the people themselves about this. It
12 is two parts. It is the health care providers and the health
13 care consumers. Keith's point is very much to the heart of
14 this. I think primary care is the place where we have to
15 provide the bulk of our mental health care. You have to do
16 this by putting the people there. If you put in the mental
17 health providers into the primary care environment, the
18 primary care environment will be able to provide the kinds of
19 support of mental health care that the consumers need.

20 If you take a look at some of the chronic
21 illnesses, if you look at diabetes, if you look at
22 hypertension, a key part of that is educating the patients
23 and their families about what they have to do to keep
24 themselves healthy. So it has really got to be a package, a
25 matrix of activities by the providers and the consumers of

1 health care, and doing this in terms of public education, and
2 also doing it in terms of professional education, so it
3 becomes a natural kind of thing for people to expect.

4 We have been able to do that in disaster response.

5 I think we are increasingly able to do that in chronic
6 illnesses such as diabetes and hypertension. I think it
7 gives us a road map for what we can do, and an idea that we
8 can in fact be successful in doing it.

9 MS. HUTCHINGS: So urgency and hope with that too,
10 I'm hearing.

11 MR. BRAUNSTEIN: There is nothing that has been
12 said that I disagree with, but I would like to emphasize my
13 support of both the statements of Kathryn Powers and Dr.
14 Gary. We have to be careful if we are going to position
15 ourselves to be more in the mainstream, that we have to be
16 clear about what it is that will be in the mainstream.

17 I think that first and foremost we have to send a
18 very clear message that mental illness and substance use
19 disorders are biological disorders that need treatment every
20 bit as much as any medical condition. Then secondarily, our
21 profession is needed for the subsequent secondary issues that
22 are there, including prevention, including dealing with
23 responses to trauma.

24 What happens now is, we get so diffuse in our
25 message about who we are and what we do, that we create in

1 many ways our own isolation.

2 MS. HUTCHINGS: This is the prioritization you
3 talked about before.

4 MR. BRAUNSTEIN: And of course the urgency around
5 that prioritization as we take a look at what will be a
6 priority for limited funding that will be available for all
7 people and services.

8 DR. WANG: I guess the way that I look at it is
9 also in a very broader picture of what is happening in this
10 country. First of all, there is a national agenda on health
11 care reform, number one. I think that is really a driver in
12 terms of where we fit in in terms of mental health and
13 substance abuse.

14 The other thing is, both at the federal level as
15 well as the state level, in different states there is the
16 mental health parity, and how that fits in, in terms of the
17 larger discussion, whether it is at the national level or the
18 state level, in terms of health care reform.

19 In Massachusetts, the most recent parity just
20 passed is expanding mental health, not only in terms of
21 limited diagnosis now, the full DSM diagnosis as well as
22 substance abuse. So I think that is a great step forward.
23 The question is then, how do you bring that into the health
24 care reform discussion, both in terms of cost and quality.
25 Someone here already mentioned a little bit about the cost

1 issue.

2 I guess something to take home, just by listening
3 to everyone, going back to the original question about
4 vision, I would just say that first of all, it is our
5 responsibility to eliminate stigma. Unless we have leaders,
6 politicians and everyone else can really truly talk about
7 mental illness. If not, I think it is very difficult as the
8 message getting out that mental health is part of the overall
9 substance abuse, as well as part of the overall health care,
10 as well as well-being.

11 The other vision is, I think we have to say it
12 again and again about mental health and substance abuse
13 treatment. They do work. How do we convince again
14 politicians, funders and so forth that it does truly work. I
15 think that falls back into how do we demonstrate that,
16 whether we talk about evidence base or whether we talk about
17 practice based evidence and so forth.

18 I think these are the areas that we need to -- I
19 think ourselves taking responsibility. As Keith said
20 earlier, we have some of the knowledge, we have some of the
21 skills, but how do we get that across and then being a fabric
22 of the whole health care reform of this country.

23 MS. POWER: I think one of the other things that is
24 important in looking at a longer term vision for five to ten
25 years is that derivative of that vision will be our mission.

1

2 So some of the retrofit for me for this discussion
3 is, I remember I had fantastic ideas when I was outside the
4 federal government about what we should be doing in our
5 vision, until I got into the federal government. Then I
6 realized that I couldn't do anything unless Congress let me
7 do it.

8 One of the things that I think is important for all
9 of us to figure out is how do we take this vision, which
10 includes by the way a series of activities which may or may
11 not resonate with Congress and may or may not be dictated by
12 Congress, and try to figure out how that fits into something
13 that we currently do.

14 One of the things that we currently do at SAMHSA is
15 that we build access, capacity and effectiveness. That is
16 what we talk about all the time when we talk with our
17 funders. We talk about building access, capacity and
18 effectiveness. I still think that resonates across our
19 agency relative to what we could do. But now we have to make
20 that fit into a public health vision, not just a mental and
21 substance use condition vision.

22 So I think that is helpful for people to know. I
23 think there is a lot of work we could do in access, capacity
24 and effectiveness, but now under the public health umbrella,
25 which I think makes us think differently.

1 The other piece to that is that we do three things,
2 it seems to me, in terms of placing the vision and the
3 mission. The first thing we do is, we try to influence. We
4 try to influence and persuade. Though sometimes it is hard
5 to sell that to our funders, that is really our business. On
6 top of that I would put leadership, which was my first
7 statement. But we are leading, but we are also trying to
8 influence and shape and persuade. That is one thing we do.

9 The second thing we do is, we give out service
10 grants, and the third thing we do is, we give out
11 infrastructure. The balance of persuasive strategies,
12 service grants and infrastructure grants has to make sense to
13 the people that are giving us that money. We need to think
14 about those as the tools that we have in our vision as we
15 think about the public health positioning. I think that is
16 an important practical reality.

17 MS. HUTCHINGS: This is where Kathryn leads ahead,
18 because the next two group conversations will be about, in
19 the next five or ten years what are the practical strategies,
20 and then the latter part being what are the effective
21 partnerships to get there.

22 Staying with the vision for now as well. Kana,
23 thoughts?

24 MS. ENOMOTO: I appreciate that many of the
25 comments from the group have been directed toward health

1 care. I realize most of us are from the care systems.

2 But if you look at some of the readings and if you
3 think about broadly where our health system is going, we are
4 dealing with the national survey on drug use and health, it
5 tells us that it is a 95 percent treatment gap on the
6 substance use side and a 40, 50, 60 percent treatment gap on
7 the mental health side. Even if we insert ourselves in
8 systems, other systems that are already overloaded and trying
9 to figure out what to do for themselves, like primary care
10 and public health or emergency rooms or other parts of
11 physical health care, I don't know that that is necessarily
12 the fix.

13 We have to look at these other systems. These
14 other systems are evolving just as we are evolving. So
15 primary care is not a static thing. American Academy of
16 Family Physician would say a lot of primary care was set up
17 for acute care, not chronic disease management, so they are
18 trying to evolve what they do. Public health is saying, we
19 are a stigmatized and marginalized part of the overall health
20 system. We need to change who we are and what we are. We
21 need to insert health into all policies.

22 So it is not just about the Department of Public
23 Health, but it is also what is housing doing, what is
24 education doing, what is criminal justice, child welfare. So
25 when we talk about parity or how can we get into primary

1 care, I don't think that is going to get us necessarily out
2 of the deep hole that we are in.

3 So I would encourage folks to think about how do we
4 insure that kids who are in foster care before they
5 demonstrate active disorders or need for treatment, that we
6 intervene early, that we provide supportive services and wrap
7 around them before they come into our systems. Or how can we
8 -- like Keith said, how can we offer some of the technologies
9 that we have.

10 The public health system is asking itself, how do
11 we encourage communities to rally around concepts of health,
12 to create green spaces to provide healthy food? We have
13 really excellent community coalition building practices. We
14 can bring that to you. So it is not just about what we bring
15 to the health care system, but overall, other systems, how
16 can we help them galvanize, mobilize and understand and
17 prioritize behavioral health.

18 MR. CROSS: I was struck in the readings with the
19 Kaiser Permanente data out of San Diego, and particularly the
20 area of child abuse. I have been working on child abuse
21 prevention my whole career, and it certainly was an
22 affirmation of the need to address that issue.

23 How that cycles me back to a vision is related to
24 this public health model. You really have to start treating
25 the child well-being as a public health issue, alongside the

1 protective and policing factors that are currently addressed.

2 But the data shows also that given a certain set of
3 circumstances, that child abuse and neglect will occur, and
4 the correlates are very clear, poverty, substance abuse and
5 untreated mental health problems.

6 So we have a cycle of problems going on. If those
7 are the contributing factors to child abuse, and child abuse
8 is one of the contributing factors to poorer outcomes in
9 health long term, which coupled with the mental health
10 problems that are associated with those poor outcomes, it
11 seems like there is a package here that you have to get at
12 through a public health model. You have to bite that off one
13 bite at a time.

14 I think one of those bites for SAMHSA is delinking
15 the diagnostic label of how services are defined and paid
16 for, from having to have an FED label in order to pay for
17 mental health services, we have to have trauma informed
18 public health and trauma informed services and payment
19 structures, so that people identified who are in that high
20 risk category, whether it is a crime or whether it is a
21 natural disaster or child abuse or serious physical illness
22 or trauma and loss, that those children can get services,
23 people can get services and have them legitimately paid for
24 without having to exhibit symptoms that get them an SED label
25 or some other label.

1 MR. STARK: When I think about how to create
2 change, whether that be at the local level, the state level
3 or the national level, I come to realize that a lot of us are
4 different people. We have different values, we have
5 different passions.

6 I tried for years in Washington State on the
7 alcohol/drug side in a previous life to try to get
8 legislators and others to support the expansion of
9 alcohol/drug treatment. What I discovered is, when I tried
10 to do that via the passion route, not everybody had the
11 passion to serve that population.

12 So over the course of a number of years, we began
13 to document what is the impact of not providing those
14 alcohol/drug services on all these other systems. We created
15 a mantra. That mantra was, funding alcohol/drug treatment is
16 an investment in health care cost containment and public
17 safety.

18 Those two issues, health care costs and crime and
19 public safety, are still major topic areas today, and that
20 mantra is still good. But you really have to take a look at
21 if you are trying to sell something, telling people who might
22 purchase it why they should purchase it, and it needs to fit
23 into their values.

24 So that begs the question of, to what extent can we
25 document the implications, i.e. costs, both human and

1 economic, of not providing these services, and the value to
2 all of those other systems of providing these services. I do
3 believe that that is an agenda that SAMHSA can continue to
4 move forward on.

5 But I also know that that data in and of itself is
6 useless if you don't know how to package it and you don't
7 know how to market it. So that is another focus area I think
8 SAMHSA can be extremely to the local states and provides and
9 counties and tribes.

10 But SAMHSA's money isn't all about the research per
11 se. It is going to require the collaboration with the
12 institutes, and to what degree can you get the institutes to
13 continue to focus more attention on services research and
14 looking at administrative databases to be able to determine
15 the cost shifts that occur in other systems when mental
16 health and alcohol/drugs don't get funded, or the cost
17 offsets that occur when they do.

18 MS. HUTCHINGS: So am I correct in saying part of
19 what I am hearing your vision is is that there would be an
20 appreciation among health systems of what would be the loss
21 of not attending to mental health and substance abuse issues?

22 MR. STARK: Well, the actual vision in my mind
23 would be that here in the United States, that we recognize
24 the value of funding mental health and alcohol/drug services.
25 Before we can get people to buy into that, we have to

1 document that value and get the word out.

2 DR. HUMPHREYS: I agree completely with what Ken
3 just said. I am going to speak as Tom Kirk for a minute, to
4 repeat a story he has told a number of times.

5 When he became Commissioner of Connecticut, he said
6 to a state legislator, I want mental health and addiction to
7 be the agenda. The legislator said to him, it will never be
8 the agenda. Your job is to make it a part of every agenda.

9 That is how change happens. One of the things that
10 holds up change to some extent in terms of realizing this
11 vision is, there is a split among us between people who are
12 willing to say, I don't care why people are going along with
13 it, I just want them to go along with it. Then there is
14 another group that is saying, no, if they don't go along with
15 this for the right reasons, they don't agree with me
16 philosophically, then I don't want to work with them.

17 I hope you understand what I am saying. In other
18 words, I don't want you to fund addiction just because it
19 will lower crime in your district, Congressman. I only want
20 you to fund addiction if you are willing to stand up on the
21 floor and say, addiction is an illness and we should have
22 compassion for addicted people. There is a big split in our
23 field about whether we are comfortable saying, okay, maybe
24 you don't agree with me on that, but this serves your agenda,
25 it serves my agenda, we are going to work together. We never

1 resolved that, and in some sense I think that holds us back
2 from becoming part of health in general, becoming part of the
3 mainstream.

4 DR. BRODERICK: Gail, just to go back to the
5 statement you made in follow-up to Ken's comments about the
6 data driven approach to enter into the health system, I have
7 the opportunity to talk to U.S. Attorneys and people from the
8 CJ system fairly commonly.

9 They would reiterate what Keith said in his
10 introductory comments. We have traded institutions. They
11 don't quite know what to do about it. They do know that if
12 they don't see people because something got prevented, they
13 are happy about it, but they are not -- I think the time is
14 right, I think that is what your point was in California
15 anyway, the time was right within the community of public
16 safety folks about engaging in that conversation.

17 So I guess I would expand a little bit your
18 feedback to Ken to include a broader systems approach to that
19 particular set of data.

20 MS. HUTCHINGS: The comments beg the question of,
21 why do we have to wait until the conditions get what they are
22 in those facilities, and why do we have to see your front
23 pages in your Georgia paper have the headlines that they do,
24 and the number of deaths that finally get attention, before
25 we are able to bring around some of these conversations to

1 why new visioning might be in order, and making sure there
2 are more voices that get to contribute to that new visioning.

3 MS. WAINSCOTT: We have had another argument for
4 many years about whether we should spend our resources on
5 people who are quote seriously mentally ill or whether we
6 should allocate them to a broader segment of the community.
7 Economics had settled that argument. We end up in virtually
8 all, not quite all, but virtually all community mental health
9 systems treating people who are very, very sick. I think we
10 have to ask ourselves how bad that has hurt our argument. In
11 other words, here we are proposing to argue for a public
12 health model while we don't do it.

13 So perhaps part of the vision is, build on the
14 national leadership that has occurred at CMHS certainly, and
15 I can't speak as well to the substance abuse side of it, but
16 to focus people on healthy students, for example, safe
17 schools, healthy students, and develop some real models
18 around the country, so that we can demonstrate, not actually
19 look forward and say it will work, but show that it works.
20 To my knowledge we just don't have anywhere a system, a real
21 system, that works the way we say we want it to work.
22 Prevent, when you can't prevent, find early, and then provide
23 the finest treatment.

24 If we were to develop some of that, I think we
25 would be on firmer ground making the argument that we need a

1 public health model.

2 MS. CUSHING: One vision would be to change the
3 public's perception about alcohol/drug problems, substance
4 abuse problems, mental health problems, to the point that the
5 public thinks of it as a health problem, not a moral failing
6 and not someone else's problem and not theirs.

7 There have been a few strides in that arena, but
8 not very many. When we talk about educating the public,
9 first of all the public has to have confidence that if we
10 talk about cancer, if we talk about heart disease, the public
11 has a perception in their mind. When we talk about the
12 issues that we are all dealing with, they have another
13 perception in their mind.

14 It is up to us to use the media and the technology
15 of today to bring people along, help them understand as Kana
16 was saying that the perceptions about the groundswell of
17 interest and commitment in the public to do something about
18 the way they eat, what they put in their bodies, the way they
19 live, their environment, has generated a buzz in our country.

20 That buzz should also include people with mental health
21 disorders and problems, people who have substance abuse
22 problems. It is up to use and our colleagues and
23 organizations across the country to do that.

24 More and more is happening as SAMHSA and other
25 agencies keep these issues on the front pages of newspapers

1 and stories on the news and in publications and the Internet,
2 but there is so much more that needs to be done.

3 I wanted to support Kana's comment about the rich
4 opportunity that lies in communities, where there are
5 functioning coalitions, whether they are substance abuse
6 coalitions or mental health coalitions, of leaders who have
7 the respect and have the confidence of the public on these
8 issues, to move this forward. Coalitions can do a whole lot
9 to help not only educate the public, but change public
10 policy. They are constituents for their elected officials.
11 They have a huge investment in some cases themselves, and
12 coalitions that have business leaders on the board, that
13 Ken's approach in Washington State with the leaders on this
14 whole idea of investing in health care and preventing health
15 problems and crime and safety. We should use that as a
16 model.

17 I truly believe, I don't think we are being a
18 Pollyanna to say this can be done. It must be done. I think
19 Carter's article on urgency is absolutely right there, but we
20 aren't pushing the envelope enough. I think that it is
21 possible.

22 MS. HARDING: First, you never put two prevention
23 people together at a table because our minds work exactly the
24 same but to add on, taking the argument or vision a little
25 further. Public education and marketing are absolutely

1 vital. If we don't get people to understand two things.
2 One, they are part of the problem, and they are connected
3 with the problem. Two, what can we do about it. Every other
4 chronic disease, we all know what we can do to prevent heart
5 disease, to manage diabetes, to look at hypertension. We
6 also know we are connected with it. We have a family member
7 or someone in our schools or someone in our community.

8 We have to change the conversation around substance
9 abuse and mental health that A, it is preventable, and
10 prevention is just not some something that people do, it is a
11 true part of the IOM model and it is a true part of the
12 progression and continuum of treatment. It is 100 percent
13 treatable when we follow the steps.

14 Those are the concepts that are not accepted in
15 this country. Ken, I love your argument of connecting it
16 with health and safety. When people know this is an
17 investment but they can't tell what investment it is until
18 they understand what it is and what it means to them on their
19 daily life.

20 MR. ALEXANDER: I think stigma has been said a lot,
21 but even within the field itself, professionals, we need to
22 look at stigma that we have among ourselves towards
23 consumers.

24 If we talk about a public health approach, what do
25 we think of our clients or the consumers, what are our views,

1 what are the views of professionals. Dr. Broderick said
2 earlier, we preach to the choir, but how is this getting to
3 new professionals that are coming out in the field.

4 I am a recent grad student, and I know. I watched
5 people in my classes who are going to go out and hurt people
6 instead of help people. So I think that maybe even looking
7 at our public universities as the venue or a venue to start
8 some of this conversation. I even waited intentionally, not
9 to say anything, to see who would comment on the role of
10 consumers, youth and families and the position of SAMHSA, and
11 nobody did.

12 So I guess that role of consumers and families is
13 to be that voice still. SAMHSA continually propelled that
14 voice. A lot of agencies, they say they want to be consumer
15 driven, consumer friendly, and they create positions. We are
16 going to have a consumer affairs position to look at consumer
17 affairs, but rarely do we integrate the voice of consumers
18 into other things outside of consumer affairs. So it is
19 stuff we need to look at.

20 DR. DELANEY: I am wrestling with my role as the
21 Director of OAS and my history of being a clinician. I most
22 closely resonated with what Ken and Keith were talking about.

23 I think as we start to think about this in terms of
24 documenting and what data needs to be there, that that be
25 part of the discussion at the very beginning rather than at

1 the tail end. It seems that even just the discussion about
2 where the consumers and families come in, if we can begin to
3 identify data sources to help us figure out what is going on
4 now at the beginning. So I wonder if this vision has a role
5 for data and documentation in parity with the vision of
6 service.

7 MS. HUTCHINGS: Would the vision for you have a
8 role for the data?

9 DR. DELANEY: Would the vision of the vision for
10 me?

11 MS. HUTCHINGS: Your vision of the vision.

12 DR. DELANEY: My vision of the vision is that data
13 and documentation is integrated into the development of the
14 vision.

15 I am not one for the idea of integrating total
16 overlap, but I liked the term that was used, partnering. My
17 sense is, integration is taught as the panacea, and I'm not
18 sure we need to integrate, but rather become part of the
19 discussion in integration. I wonder if it has taken on a
20 wholly different idea, but my understanding of integration is
21 that it becomes integrated into the system. I think if we
22 do, then we may actually lose some of our valence in raising
23 mental health and substance abuse as real issues to be
24 addressed, because then they just become part of this other
25 system, and you can drop them down in the valence of need.

1 DR. GARY: As I listen to the conversations, it
2 reminded me of many assets that SAMHSA has, the assets that
3 SAMHSA has with relationship to the population that we are
4 concerned about.

5 I think that we probably need to resonate about
6 what those assets are that SAMHSA has, so that we can be very
7 clear about what our strengths are and what we bring to any
8 table. One of them is the lived experiences of patients and
9 families who have the burden of mental illness and substance
10 abuse. I think we have the pulse on what their lives are
11 like. We have many, many other assets.

12 One of them again is the coalitions that we already
13 have established in communities. I think we just need to
14 somehow make a list of what those assets are and play from
15 the list of assets that SAMHSA has.

16 The other piece is, we can begin to look at how we
17 can provide stronger partnerships with private foundations --
18 we can't do this by ourselves -- with labor unions, with
19 church groups, et cetera, all who have certain values and
20 thoughts about substance abuse, mental illness, the causes of
21 it, how it is treated and what the outcomes are going to be.

22 Somehow in our model I think we have to grapple
23 with the whole notion that the general public does not see
24 mental illness as curable. We don't talk about cure when we
25 talk about mental illness. We talk about treatment, but we

1 don't talk about cure. I think that might be something that
2 we need to be very clear about and have a sense of how do we
3 respond to that kind of dialogue in the general public.

4 The other piece is that when we look at the whole
5 public health model, there are three basic pieces to the
6 public health model. Believe it or not, in the '60s and '70s
7 the public health model was a primary focus in mental health.

8 The development of community mental health centers had 12
9 services that had to be involved in community mental health
10 centers, and crisis intervention was one, and it was the
11 foundation of that primary piece of mental health. We don't
12 do crisis intervention anymore.

13 So I would suggest that we might also take a look
14 at that model. It is written by Gerald Kaplan out of
15 Harvard. It is an old text, but it still works. I think we
16 need to look at how is it that we lost the whole public
17 health approach to mental health and substance abuse, and
18 understand that very clearly so we don't fall in that trap
19 again.

20 MR. ALEXANDER: There also needs to be
21 understanding, just as Dr. Gary was talking about, the
22 continuum of services, some of the services on that continuum
23 that we have lost. Even the idea that mental illness or
24 mental health wellness, there is a continuum of disorder
25 there. All mental health issues aren't schizophrenia. They

1 don't look like bipolar. But they are a phase of life
2 disorders that a lot of times don't get treated because there
3 is not schizophrenia, it is not bipolar or it is not suicide.

4 So some of those phase of life disorders, that if
5 not they grow on the continuum if not treated. So even
6 understanding that mental wellness is a continuum in itself.

7

8 MS. WAINSCOTT: I hope we can remember that we have
9 had two bodies tell us recently, the first, the President's
10 New Freedom Commission, and then the Institute of Medicine,
11 that we need to integrate to the degree possible. They
12 recognize there are dangers and fears.

13 But before we decide not to do that, I hope we will
14 talk to the people who I find most in support of that, and
15 that is the consumers, the family members. They know what it
16 costs them to be in an underfunded, depreciated system, that
17 only cares for part of their bodies, up here. They know they
18 die 25 years younger than the general population. Those
19 people are less afraid of it than people who provide the
20 services are.

21 MR. STARK: This is probably a value statement more
22 than anything else. One of my pet peeves has been for a long
23 time that our education system, not necessarily the higher
24 ed, although I would include them, but K-12, does not do much
25 to teach our children how to live in the world that we live

1 in, meaning coping skills and relationship building. Our
2 education system obviously focuses on other things, reading,
3 writing, arithmetic, those are all important, arts and
4 sciences. But we need to teach people somehow, it is not
5 going to be in the education system, that we need to figure
6 out some other way to teach people the coping mechanisms,
7 because if we don't, then there are a lot of folks who don't
8 have serious mental illness per se, but have significant lack
9 of relationship and coping skills, such that eventually if
10 they don't get a handle on that, they will end up to be a
11 whole lot worse off, maybe in jail, maybe domestic violence,
12 assault, suicide, whatever. I think we really as a country
13 need to get a handle on that.

14 MS. HUTCHINGS: With the transition, before that,
15 any thoughts? George, anything? Mark? Just checking in.

16 MS. KADE: From a budget perspective, I guess the
17 vision that I would have for SAMHSA is that we are able to
18 use our entire three billion dollar budget to leverage our
19 presence and our partnerships with other federal agencies and
20 state agencies. That might not mean we do the same things
21 again and again.

22 It is not just a million here, a million there. We
23 have got three billion dollars that we can use to change, in
24 terms of partnering and leveraging.

25 MR. WEBER: I guess the quick vision statement for

1 me is, incentives are in place to achieve health. Just
2 looking in the environment we operate in, we are a capitalist
3 society, people are not perfect, we are irrational. The way
4 this country works and how things change and how things move,
5 you have to have incentives in place to get things done. And
6 the thing to get done is health.

7 MS. HUTCHINGS: So is that your vision, that the
8 incentives would be in place? Or you think they are now?

9 MR. WEBER: Might be. The incentives are all in
10 place.

11 MS. HUTCHINGS: George, anything?

12 MR. GILBERT: I have been listening to the
13 conversation, and it has been very interesting. I certainly
14 agree with everything that everyone has said.

15 I think the one thing I would just emphasize, I
16 really think it is important for us to think about how we get
17 support for providing services for mental health and
18 substance use disorders outside our field. Other people have
19 mentioned this.

20 I worked on the Hill for a number of years. The
21 first job I had up there, my job was to try to get the Select
22 Committee on Narcotics in the House of Representatives
23 reconstituted. Select committees go out of business every
24 two years. I prepared all the materials and had all the
25 arguments in line. I went and talked to a legislator who

1 wanted to know what was going on.

2 The first question he asked me was, who supports
3 this? He stopped me cold. I think that is what politicians
4 ask. They want to know who is behind it. I think the more
5 we are able to encourage the support of consumers and
6 families and the more we are able to encourage the support of
7 labor unions, business, the medical fields, the more voices
8 we have will go and say, we need what these folks provide
9 because of the cost containment issues or whatever it is, the
10 more likely we are to see progress in our field.

11 MS. HUTCHINGS: Last comment, then we will move on.

12 DR. DELANEY: I wanted to build on something that
13 Daryl said. Not only do we need to document where we need to
14 go, we need to document, we need to stop doing things that
15 aren't working or where we don't need to go.

16 MS. HUTCHINGS: Part of what I think I am hearing
17 from Daryl as well is a revisiting of -- and I would suggest
18 that we should put this on a macro level, SAMHSA and its
19 portfolio, the field resources, Kathryn's point about
20 leadership, it doesn't have to be constricted, where can we
21 go with -- I loved your assets word. I thought that was a
22 strong word to use.

23 This is trying to move us from some of this broad
24 visioning to some of this practicality based recommendations,
25 of how can we get to achieve -- whether it was Rick saying we

1 need to create these opportunities for conversations with
2 people that we don't traditionally have them with, Kathryn
3 saying we need to exhibit this leadership and bring it in,
4 yet that come in a context that needs to be applied around
5 it, all the points that you made.

6 Here are three quotes from during your interviews.

7 I love this first one. We need to get a sense of how the
8 boiler room operations of health reforms will take place, how
9 we can create a sense of urgency, some of you talked about
10 that. The focus needs to be on systemic capacity building.
11 We need to set a few key issues and focus on them, George,
12 some of the points that you had mentioned before as well.

13 So bringing this vision into a pathway that has a
14 reality frame, five to ten years, how will I get to some of
15 your vision. Faye talked about partnerships with unions.
16 People talked about being more data driven, making the case
17 for safety.

18 MS. WAINSCOTT: For me, partnerships is absolutely
19 the key. We cannot do this by ourselves. It is too broad a
20 problem, and we need too many players on our side.

21 One of the encouraging things to me is how many
22 people outside of quote mental health get this now, but it is
23 a question of how to harness them.

24 I was just called by a man who is the head of in
25 our county something called Barto Health Access. He asked me

1 to come to a meeting next week to talk about how to increase
2 the capacity to treat mental illness and substance use
3 disorders in our community. He is not one of us. More and
4 more people get it, but one of the key strategies has to be
5 how to get them involved.

6 MS. HUTCHINGS: When we finish this segment, we are
7 going to talk about some of that leveraging of actual
8 partnerships, who are they, when, how do you approach them,
9 who should approach them. So changing this transition vision
10 to pragmatic strategies to achieve that vision.

11 MR. BRAUNSTEIN: I would like to suggest -- and
12 actually it is a followup to multiple conversations and
13 points people made before. One of the major strategies we
14 need to do, in addition to being clear about what we are
15 trying to accomplish is not be afraid to give up some of what
16 we are and what we define ourselves as.

17 Everything that people do has a value to somebody,
18 and is very important in a lot of cases. But we have to be
19 careful about trying to own it all and trying to be all
20 things to all people, which I find we do more of in many ways
21 than other people in other parts of the health field. I'm
22 not saying that we become elitists in any way. I am saying
23 we have to be clear.

24 There might be instances where we can, if we get
25 into that boiler room, get certain aspects of mental illness

1 treatment of substance use treatment covered, but it might
2 fall into more of a mainstream. We may have to give up some
3 of our control over it to allow more people to be covered in
4 that mainstream, for one example.

5 Another example may be that we have to find other
6 funding streams to fund some of the long term care issues
7 that people with mental illness or substance use have, such
8 as housing, transportation and job training. We may have to
9 find other ways of getting it funded other than Medicaid.

10 So we have to learn to be clear about our
11 priorities, but then also be comfortable with letting go of
12 certain tried and true ways that we have always looked at
13 things.

14 MS. HUTCHINGS: So our own self analysis on what we
15 are willing to give up. Fascinating.

16 DR. HUMPHREYS: Since we are being more practical
17 now, the AMA is about done with creating a code to pay
18 physicians to screen for problem drinking. I suspect most
19 physicians don't even know this. So this would be a good
20 time once that is finalized to have Dr. Clark or other key
21 officials going around to all the medical groups and saying,
22 this is something we would like you to do, and you will get
23 paid for it. In other words, use the incentive that is
24 there.

25 Parallel thing I think we didn't take as good

1 advantage of it as we could have was when Medicare expanded
2 its prescription benefit. I think there is still a lot of
3 opportunity to educate families who have someone with mental
4 illness on the new coverage they can get and how they can use
5 it, and how they can maximize their --

6 MS. HUTCHINGS: The dual eligible.

7 DR. HUMPHREYS: And make sure that their provider
8 knows they have the eligibility and all that. Those are
9 huge. Those are multi-billion trains that are going our way
10 that we could help direct towards our own agenda.

11 MR. STARK: I think one of the other things that
12 SAMHSA can do, and I know that SAMHSA has already done some
13 of this, but the last couple of months I have seen more and
14 more meetings and been involved in more meetings with various
15 funders, not just government funders, but also various
16 foundations including the Gates Foundation and others, who
17 are all coming to the realization that none of us in a vacuum
18 can do it all.

19 Many of these foundations historically used to be
20 very quiet in the background, they did their own thing, they
21 identified the priorities and they did their funding. They
22 over the course of the last five years, ten years, have
23 formed local regional associations and national associations.

24 They are beginning to go around now and meet with local
25 government, county executives, county councils, as well as

1 state folks, governor's office and the state legislature, to
2 talk about how can we work together to identify priorities.

3 It may not be a bad idea to, as SAMHSA has
4 continued to work with other federal funding agencies,
5 whether it be Justice agencies or CDC or whoever, it may not
6 be a bad idea to start pulling together some of these major
7 foundations, and sit down and do some strategic planning
8 together with them.

9 Clearly there are many overlapping agendas, but
10 money is getting more and more difficult. To the extent that
11 we can mitigate if you will duplication, overlap, and be more
12 strategic about how we tie the various funding source pieces
13 together when there are certain communities that are going to
14 be targeted, I think it is all to our advantage.

15 I'm not just talking about foundations that fund
16 alcohol/drug services or mental health services. They fund
17 maybe employment, economic development, maybe education,
18 child welfare, whatever.

19 DR. WANG: In trying to answer the second question,
20 first of all, I think change has to start somewhere. We can
21 keep talking about it for years, somebody already mentioned,
22 and also the article that talked about the urgency.

23 I think part of it is looking at prioritizations in
24 terms of SAMHSA. First of all, it is looking at some of the
25 assets, the activities that SAMHSA has accomplished over the

1 last number of years, and then how to bring those activities,
2 those assets, to the table that ties into the principles and
3 approaches in terms of the whole public health.

4 The interesting thing is that it always strikes me,
5 even at the state level, when I start traveling out to the
6 communities, earlier talk about coalition and so forth, I am
7 always amazed that there are pockets of excellence happening
8 in Massachusetts and in other parts of the country as well.
9 Maybe they are much more of a micro level at the community
10 level, but these agencies got the work done. Certainly they
11 have got their struggle. They have to go through their own
12 transformation and change, but the commitment is there at the
13 local level.

14 I have seen organizations that are providing mental
15 health, substance abuse, social services, on top of
16 everything else that the community needs. I am always amazed
17 and say, how do they do that. Then when you ask them and when
18 you sit down with their financial person or their executive
19 director, they will lay out in terms of where the funding
20 comes from, Medicaid, Medicare, foundation dollars, da da da.

21 So that has always impressed me at the micro level.

22 Then when I move back to the state level and I say, what is
23 the challenge, what makes it so difficult at the state level
24 or in this case also at the federal level, to facilitate, to
25 empower those changes. That always to me is really the true

1 challenge. A system like SAMHSA that has to work with
2 multiple agencies and multiple leaders to make that kind of
3 level of -- higher level of commitment.

4 So I think one practical approach is, I do like a
5 number of things that SAMHSA has been doing, and I don't need
6 to go through those in detail. I think they have true impact
7 in terms of a public health model.

8 I think the final thing I want to say is that one
9 of the things that I have learned from the public health
10 folks is that once I begin to talk their language and using
11 their approaches in terms of planning populations, race,
12 ethnicities and where are the disparities and so forth, then
13 I think we are beginning to talk the same language. Then
14 beginning to say, we can work together on this, suicide,
15 depression, Asian or Latinos, adolescents and so forth. Then
16 we are beginning to talk the same language. Then I think our
17 willingness to say, let's do some sharing of cause in terms
18 of prevention and also early intervention.

19 DR. HUMPHREYS: This is a question, and you can
20 probably answer it as well as anyone, Gail, but also designed
21 to push on the discussion of the nuts and bolts. I have hung
22 around SAMHSA for a number of years ,and never really known
23 how much does SAMHSA and CMS, how much do they talk, do they
24 interact?

25 CMS obviously spends more money on mental health

1 than any other federal agency, and they are a place where
2 mental health and regular health are in the same building, at
3 least. Can you just illuminate, is there a relationship? If
4 so, what is it like? Does SAMHSA have any influence?

5 MS. HUTCHINGS: I think I could, but it probably
6 wouldn't be appropriate for me to, so I will ask either Kana
7 or Kathryn to speak to that.

8 MS. POWER: I'll start. CMS is a partner with us,
9 and is a part of the Executive Steering Committee, and part
10 of the Federal Senior Partners Work Group. So they are a
11 visible presence. We have actual names of people and real
12 people at CMS that participate with us. Sometimes that is
13 the hardest thing, is trying to find the right people in a
14 large organization that is ten times the size of SAMHSA, I
15 might add.

16 What they have done in their partnership with us
17 and that we have encouraged is, we have selected particular
18 topical areas around transformation that are barriers to
19 change, much of which are financing issues that are related
20 to some of the Deficit Reduction Act issues, some of them
21 relating to coding, some of them relating to definitions that
22 have been adopted by various regional centers and regional
23 offices, and trying to demystify what we call the Medicaid
24 urban legend that was out there relative to states.

25 We found that transformation for people at the state

1 level in involving the financing of Medicaid and Medicare
2 funded services was really based on a lot of misinformation
3 on this.

4 So we have spent a lot of time trying to get much
5 more facile with each other, not only as agencies, but also
6 to build that connection back to the states and the regional
7 offices. I think we are making progress in that, Keith.

8 So I see that as a terrific effort to open the
9 doors and the windows across the agency to explain and
10 understand each other's values, because we are both in the
11 same business. For too long, there was this issue about,
12 SAMHSA is a recovery focused agency that wants to do evidence
13 based practices and CMS is an agency that wants to figure out
14 ways to meet the Deficit Reduction Act. We didn't get to the
15 point where we were trying to share values and talk about how
16 we are really both in the same business, in terms of hoping
17 to support recovery.

18 So I see the relationship as continuing and
19 continuing to grow. They have taken some great steps in terms
20 of doing some of the transformation grants and money follows
21 the person. I think they have larger demands financially in
22 terms of goals that they have to meet.

23 But we are really focused at the federal level on
24 problem solving and trying to help people get rid of the
25 barriers that are in the way. For example, you used to be

1 able to not bill for a primary care visit and a quote
2 behavioral health or mental health care visit on the same
3 day. We got rid of that barrier. We were able to clarify
4 that you can bill in a clinic for both services on the same
5 day.

6 So we are trying to get at some of those issues
7 that are helping operationally people to be able to use
8 Medicaid. We have also partnered with CMS and HUD and
9 several others on the SORE program, which is making sure that
10 people are -- there is an expedited review for social
11 security eligibility determination, and we are doing great,
12 great things. So every state who is now a SORE state can get
13 someone SSA eligible, which is the doorway to Medicaid and
14 Medicare, in a much more expedited time. CMS has been a
15 partner with that.

16 So in those ways, I feel it is very strong. Kana
17 may want to mention something about the agency going forward
18 with some other ideas.

19 MS. ENOMOTO: One of the important initiatives that
20 came forward under Dr. Cline's leadership is SAMHSA's Center
21 of Excellence for Behavioral Health Financing. I think that
22 is an almost awarded contract, I think awarded, that will
23 allow us to take a more comprehensive view of financing,
24 including expenditures and costs, cost benefit, and help us
25 make a clearer statement of the values proposition for

1 behavioral health services.

2 We are in a series of ongoing discussions with
3 current and former leadership at CMS on how to help us better
4 translate our case for different services in language that
5 CMS and the people that are working on regs there can better
6 understand.

7 I think translating much of what we know and feel
8 into hard numbers is what we need help doing. There are
9 oftentimes things that we believe exist on the behavioral
10 health side, mental health side. Then when you go digging
11 around for the numbers, people say we don't have those
12 numbers, or I'm not sure which numbers you mean. It is not,
13 pull it off the shelf and here is the financial case for
14 community based mental health services. It was quite a
15 challenge to pull that together, and more of a challenge than
16 it should be, frankly. This stuff should be rolling off the
17 tip of our tongue, and it is not right now.

18 I think to the degree that we can become more
19 fluent in the language of financing and value, it will help
20 us in our relationship with CMS.

21 DR. HUMPHREYS: Just to bring it back to our
22 conversation, I appreciate people saying that, but I'd just
23 emphasize how hugely important that partnership would be, not
24 just because CMS is the biggest buyer, but also because
25 Medicare policy then influences what private health insurers

1 do oftentimes.

2 MS. HUTCHINGS: Before we hear from George, one
3 reason I punted on your question is disclosure. A client of
4 mine is the winner of that contract too, so I want to keep my
5 neutrality here.

6 MR. GILBERT: I just wanted to add a quick point.
7 Keith mentioned the AMA codes for ESPRT. SAMHSA and CSAT
8 work very closely with ONDCP in developing with CMS codes for
9 Medicaid and Medicare reimbursement for ESPRT as well. So
10 that is an area where we have been able to really have an
11 influence and create some opportunities to help broaden the
12 integration of alcohol and substance use disorder treatment
13 with primary care.

14 MS. HUTCHINGS: I think it is obviously, but it
15 should go without saying that one would think there would
16 need to be a continuing strategy to employ this close
17 collaboration. But Kathryn's point, George's point about,
18 what are those real issues that are getting in the way of
19 finding other leverage points, financing options, et cetera.

20 Those are two huge barriers that got removed and
21 are tremendous progress, I think. So if you have other
22 thoughts about what some of that collaboration be, what
23 should the focal aspects of those be.

24 DR. GARY: Your comment just reminded me of the
25 Institute of Medicine's document on equal treatment. In

1 there it clearly defines three interlocking segments that I
2 just wanted to mention. I think it would behoove us, when we
3 talk about the practical issues to use that model when we
4 describe them.

5 It talks about the patient and our families and
6 communities would be our issue. The other is the system, and
7 that is what Kathryn just finished talking about. The other
8 is the health care providers, which we have not talked very
9 much about. I think Marvin mentioned the health care
10 providers.

11 But when we look at our vision and what we wish to
12 do, we have to have informed people who know how to speak a
13 language as you point out, have a certain kind of attitude
14 and a knowledge and skill set. So we have to look at
15 workforce issues as well. We have to look at the cultural
16 competencies. We have to look at who is informing the care,
17 and we also have to look at the research that we have
18 available to us and how we can use that research to maximize
19 the outcomes that we wish to do.

20 So again, as we look at a practical overview, I
21 think we need to consider the patient, the system and the
22 provider.

23 MR. BRAUNSTEIN: Another aspect of strategy that
24 needs to be considered here is that whatever the priority is
25 that moves forward, I think there needs to be some really

1 powerful leadership development at the local levels.

2 I'm not speaking now about some of the things that
3 the National Council does mostly with middle management. I
4 am speaking more around the model like the American College
5 of Health Care Executives does around hospitals. That is,
6 the fact is that the kind of leadership that is needed in
7 systems, whether they be regional or local, to maneuver and
8 manage in tough times and especially to be able to deliver,
9 needs to be more consistent.

10 I agree with Ed that you can see some really good
11 stuff at a lot of local levels. But I don't think there is a
12 consistency that needs to be there. I think that is one of
13 the barriers to state and federal level people getting more
14 things done consistently across multiple sites. It is
15 because the inconsistent leadership and the tendencies for
16 some who have moved up from a service provider level into a
17 leadership role to still think of themselves as a clinician
18 instead of an administrative professional of the health care
19 system.

20 MS. HUTCHINGS: And of course that word
21 sustainability comes in when you are talking about pockets of
22 innovation that are at the local level, too. It is
23 leadership sustainability, which I think we will talk about
24 more this afternoon as well.

25 MS. POWER: Let me just hook on a couple of things.

1 First of all, when we talk about sustainability, for me it
2 is always the issue of leadership and having a core
3 leadership and a leadership that will sustain itself over
4 time, and that will be given the opportunity to lead for
5 certain periods of time. I think that is absolutely
6 essential.

7 But in the area of sustainability, what we have
8 found in transformation is that you have to get your arms
9 around sustainability by talking about scale and scope.
10 Sometimes when you start talking about vision and you go to
11 strategies, it is very hard for people to get their arms
12 around the scale and scope of the change, when you are trying
13 to keep the sense of urgency alive. How do you keep the
14 sense of urgency alive if you can create this one thing and
15 this change, that feeds your own sense of urgency, but then
16 you have to step back and say, wait a minute, are we going to
17 talk about much larger scale and scope if you are taking the
18 public health approach.

19 So for me, the issue is trying to start to do some
20 influencing strategies more practically. Faye reminded me
21 when she talked about the 12 services -- thank you for
22 remembering -- one of those services was public education, as
23 you recall. That is when we got out of the public health
24 business, because we weren't going to do public education
25 anymore, because we scrambled those 12 services into five

1 services, and you all remember that very well.

2 Which gets to the issue that Ken raised around, are
3 we in the business of public education. Well, yes, we are,
4 but we don't have necessarily a campaign unless we have a
5 specific campaign to change the minds and hearts of people.

6 I have found that working with the public education
7 field on the federal level is a tabula rasa. They are
8 welcoming and open to any kind of ideas related to how do we
9 build a social and emotional competency agenda in schools.
10 Whether or not we can move that forward is another question.

11 Then I go to another state and I see, that is all dependent
12 on the leadership, all dependent on the leadership in the
13 state if the mental health person and education person will
14 do that.

15 So again, cultivating the leadership, and also
16 trying to do the kinds of work that we can do with other
17 sectors, and model the way around the fact that mental health
18 and substance use conditions have to be incorporated as a
19 health issue, if we achieve Mark's vision, health issue for
20 everyone, and begin to get a specific strategy with education
21 about that, which I think highlights the prevention model as
22 well.

23 The second area besides education is the workforce
24 development issue, and I know Marvin and Faye were just
25 talking about. We are struggling with what do we do about

1 influence and workforce, where do we go. The consumer and
2 families are hugely important in helping us influence where
3 we go with workforce, but I still think that there are some
4 more practical strategies that we could come out from this
5 regarding a focus on public education in a public health
6 context and cultivating -- and we keep on saying we are going
7 to grow our own workforce. What does that mean, and how are
8 we going to then influence that workforce to be able to then
9 deliver the kind of service that our good leaders are going
10 to be telling us to do.

11 So I think trying to weave this issue about skill
12 and scope and trying to look at some specific strategies
13 about the leadership development issue, and then particularly
14 focused on public education and on workforce development
15 would have some merit about the next steps.

16 MS. HUTCHINGS: Kathryn, can you give me -- with
17 this lens of a five to a ten year time frame, can you give me
18 one strategy that you would support under those two
19 umbrellas? So one leadership relevant strategy that would
20 play out the next five to ten years.

21 MS. POWER: I think we should have policy academies
22 in every state in the next six months that would host both
23 public sector, provider, consumer and family leadership, and
24 have specific leadership institutes for those people to work
25 in their states.

1 MS. HUTCHINGS: And since you did such a good job
2 with that one, can you give me a workforce one? Do you have
3 a separate workforce one that you would offer as well?

4 MS. POWER: I think one of the workforce strategies
5 just from a policy standpoint is, SAMHSA is often looked at
6 as not being in the workforce business. Congress doesn't
7 look at us as cultivating the workforce.

8 One of the barriers may be to try to change our
9 approach and our authority to be able to influence the
10 workforce across the disciplines that we know are coming, and
11 also think about a specialized program for cultivating peer
12 support services and training, peer support and family parent
13 professionals and other groups that we know may be involved
14 in the workforce, and doing a specialized program in that.

15 I think the workforce matrix has a couple of other
16 ideas that I am just not remembering at this moment.

17 MR. CROSS: I had two related strategies. One is
18 to look at tax policy. In a number of fields, reform in tax
19 policies brought about change, whether that is economic
20 development, housing, child care and adoptions, just to
21 mention some of those. I think this idea of involving the
22 private sector and involving the employers is an extremely
23 important aspect of this.

24 The other related strategy is involving health care
25 economists in being able to tell the story. One of the

1 reasons we even have a child care tax credit is because of
2 the research that was done that demonstrated the cost of not
3 providing child care to the employees, and the amount of
4 resources that it takes when someone has to leave work. So
5 once the corporate sector was convinced that child care was
6 an economic win for them, we saw the child care and
7 development block grants, and then under welfare reform an
8 expansion of that, and the tax credit.

9 So this is a systemic change. You could imagine
10 mental health tax credits similar to enterprise zones, where
11 there are significant populations in need without service. I
12 can even imagine tax credits for individuals in getting
13 screenings, or if you have got a child that has got an FED
14 diagnosis, the recognition of that in a family that adopts,
15 gets a tax credit.

16 So beginning to normalize throughout the system,
17 and also reducing stigma, that if it is tax policy it is part
18 of our normal responding to a societal issue.

19 MS. HUTCHINGS: The creativity prize of the morning
20 so far goes here.

21 MR. STARK: A couple of things, tied to workforce,
22 which is an area that is a big interest for me.

23 Clearly on the health side and on the alcohol/drug
24 side, we have got challenges around workforce, not unlike the
25 health care in the general field has. Health care in general

1 though over the years has done many different things that
2 nurses and doctors used to only be able to do, and now all
3 kinds of other people can do.

4 We need to do that same analysis in alcohol/drugs
5 and mental health. What are the competencies that we really
6 need? What are the practical skills folks need? Does it
7 really require a master's degree? Does it really require a
8 bachelor's degree? Does it really require an MD, a nurse, a
9 PhD? Or does it require a clear training training program of
10 one year, maybe two years, that could be done through a
11 vocational school, it could be done through a community
12 college, could be done through a university.

13 But in addition to that, we also need to look at
14 our degreed people. We have a ton of degreed people coming
15 out with degrees up the ying yang, but not knowing about
16 evidence based practices and practical applications. Again,
17 that is where we have got to focus on those colleges and
18 universities, and can we get them to change curricula.

19 I know we had some of those conversations in
20 Washington State, and there is some interest at the
21 University of Washington and Washington State University and
22 some other players, both relative to creating succession
23 plans, where individuals can start off getting a one year or
24 two year certificate that might be applicable, to move on
25 eventually to a B.A.

1 But it gets back to what do we really need. All
2 that training and education is for naught if we don't have
3 employers who aren't going to hire them. So it means that
4 the employers and the consumers and the families all need to
5 be at the table along with the educators as we develop those
6 core competencies and certificate programs, some of which can
7 be tied to degree programs, some of which can be independent.

8 I really think that SAMHSA working with Department
9 of Labor and workforce development, economic development
10 entities could do some things around that area. Some of that
11 discussion is going on now, I know, but I think we have some
12 real opportunities there.

13 MS. HUTCHINGS: Good point. And per last time,
14 where the transition to the last word on this one comes?

15 DR. DELANEY: There are a couple of comments. One
16 of them is that just simply getting the competencies isn't
17 enough. One of the problems is, you can train these people
18 where you want them to be, but when they get into the
19 systems, the systems function a certain way to retrain them
20 to meet what the system wants them to be. So there has to be
21 a competency of the system as well.

22 The other thing. As I am listening to all this,
23 the one that I most resonated with was, we need to select a
24 few key issues and focus on them. As we are talking, I keep
25 thinking of one thing that happens in disasters a lot. We

1 call it mission creep. I think the parallel statement is, we
2 need to identify and focus on a few key roles. Sometimes I
3 think as I listen to this, we are getting to the point where,
4 are we a federal agency or are we a state agency, are we a
5 local community provider.

6 So as we select issues, we need to identify what
7 role does SAMHSA have in helping to build that issue. Do we
8 need to, as Faye talked about, build a relationship with
9 other federal agencies such as NIH to increase the sense of
10 urgency? Do we need to be a capacity builder by grants, or
11 are we going to be out there running things? I don't know,
12 but I am just saying that if we allow too much mission creep,
13 we become all things to all people, and I think we lose our
14 effectiveness as a federal agency.

15 MS. HUTCHINGS: I think one of the nice ways that
16 SAMHSA has constructed these discussions today and tomorrow
17 morning is in part so this input, the wisdom of the NAC
18 members comes back to SAMHSA's ELT, entire staff, and you get
19 to come back around the table and help with that role
20 definition, boundary setting, et cetera.

21 We are going to leave for lunch at 12:30. You will
22 be transported.

23 MS. WAINSCOTT: Can I say one quick thing?

24 MS. HUTCHINGS: Yes, and then we are going to do
25 our last one.

1 MS. WAINSCOTT: We talk about elevating behavioral
2 health care in general medical settings. We can't do that
3 without talking to people who run general medical settings,
4 and I'm not sure we have done a good job of that. We just
5 need to find out from them what is keeping them from doing
6 it. They seem to want to do it, the ones I have talked to,
7 but they have barriers, and I'm not sure we even know what
8 they are.

9 MS. HUTCHINGS: I think part of what is being
10 encouraged today is also to broaden that. It is not only
11 general medical settings, it is health, not only health care,
12 not only primary health, a term you can't stand, so I'm going
13 to use general health care.

14 MS. WAINSCOTT: Physical health care.

15 MS. HUTCHINGS: Physical health care, right. So
16 even broader, for health what are some of those dialogues
17 that need to occur.

18 Here is the last part of this morning's
19 conversation. This is just one more step. Vision,
20 recommendations within a five to ten year window, to even now
21 more specifically about partnerships. Most of you have
22 mentioned that word sooner or later this morning.

23 Here are three quotes from among you. We must make
24 the case that health reform efforts that do not improve
25 behavioral health would be incomplete. We need to generate

1 real data to demonstrate the negative health consequences
2 associated with failing to provide behavioral health
3 services, sort of a cynical twist on Ken's statement before.

4 How is the message of SAMHSA changing as a public health
5 agency.

6 Thoughts about how do we use some of the coalitions
7 that exist now to get even closer, what are some of those
8 partnerships that you mentioned before that need to take
9 place?

10 MR. STARK: I do believe that the states working
11 with their community stakeholders, which would include
12 tribes, counties, coalitions, providers, do need to work
13 together pursuing those agenda items.

14 But on a national level, if you think about
15 Medicaid, you think about CMS. Now, mental health is pretty
16 entrenched in that system, sometimes to its detriment.
17 Alcohol/drugs is not. In fact, you can go to a lot of states
18 where they don't allow Medicaid to fund alcohol/drugs
19 services. There is some question in my mind of, why not?
20 Doesn't anybody who understands the data -- doesn't a
21 Medicaid director understand their own data? Don't they
22 understand that if they don't support allowing alcohol/drug
23 treatment as a reimbursable service in their Medicaid
24 program, that they are increasing their acute care and long
25 term care and medical costs?

1 So part of my hope would be that SAMHSA could
2 encourage CMS to essentially -- as they are out there talking
3 with their own state folks and at their conferences, looking
4 at chronic care intervention strategies and fraud, waste and
5 abuse, that they also incorporate the value of allowing
6 alcohol/drug treatment in their Medicaid plans in each state,
7 as part of that chronic care improvement strategy and that
8 fraud, waste and abuse strategy.

9 MS. HUTCHINGS: Can I get you to expand that to not
10 only be SAMHSA focused, but what should the fields do? How
11 should state SSA directors -- we are talking about plan
12 amendment changes and all the technical stuff. Can you tell
13 me a more field driven, field owned --

14 MR. STARK: I think that is consistent at the state
15 level as well. I don't think it is any secret around this
16 table that there are some states where the alcohol/drug
17 agency and the Medicaid office don't even know each other.
18 There are some where they can't stand each other. There is
19 this whole system of relationships or the lack thereof.

20 So I really think it is important that the
21 advocates, community coalitions, providers, counties, tribes,
22 work with their states and encourage that partnering at the
23 state level as well, and help produce the documentation, or
24 if the documentation is already there, help market the
25 documentation of why those entities need to work together if

1 we are to serve people as a whole, mind, body, spirit.

2 MS. POWER: I would ask CMS, do they bring in
3 everyone who comes in as a state Medicaid director, and do
4 they do training for them. And if they do do training for
5 them, SAMHSA should be a part of the training program, to
6 talk about what they should know about the realities of
7 mental health and substance abuse.

8 I don't even know the answer to their question,
9 whether CMS does that. But their Medicaid directors are
10 changing just as frequently as mental health and substance
11 abuse directors are changing. We ought to do some joint
12 training with them, which would get at that issue, Ken.

13 MR. STARK: Yes, it is key, it is absolutely key.

14 MS. HUTCHINGS: Other partnership based
15 recommendations that will help achieve the vision?

16 MS. WAINSCOTT: I would applaud the move towards
17 CDC. Living in Atlanta, I have been acutely aware for years
18 that there has been one person on staff with no resources
19 thinking about mental health. So this is a huge thing. When
20 you think about the public health agency in the country, it
21 is a great partnership.

22 So I don't know how to build on it, but we need to
23 focus on that.

24 MS. HUTCHINGS: I would applaud Dr. Curie for
25 moving on that. That is exceptionally important.

1 MS. ENOMOTO: I think one of the steps that SAMHSA
2 is making is by having this conversation with the National
3 Advisory Council, and encouraging you all to do this. Each
4 of you is a leader in the field. Just as we have started
5 this conversation with you, I hope that you take it back and
6 have a conversation where you are.

7 Just as Dr. Cline in SAMHSA has made the move, we
8 have reached out. We have reached out to CDC, we have
9 reached out to NACCHO and ASTHO and National Association of
10 Community Health Centers, Association of State and
11 Territorial Health Officials and National Association of City
12 and County Health Officials.

13 We didn't wait for them to invite us to a meeting.
14 We asked to have those meetings. Similarly, I think if each
15 of you does the same thing, I know you are all very busy, you
16 get invited to do a lot of speeches. Perhaps maybe every
17 tenth one, instead of going to one that you would normally
18 do, reach out and say, is there a spot for me on the local
19 hospital association or at the state Medicaid meeting. We
20 will have to be aggressive about this. They are not knocking
21 on our doors to come to our meetings.

22 As Tom said, we want to make our agenda the agenda;
23 no, I think what we need to do is get on to their agenda. By
24 doing that, we offer them something.

25 MS. WAINSCOTT: And Kathryn's leadership counsel

1 could turn that into reality.

2 MR. CROSS: I just want us to think about who are
3 the thought leaders and the need to build broad coalitions.
4 The importance of think tanks right now is extremely
5 important in shaping public policy. Whether it is the Pew
6 Charitable Trusts and several of the things that they do or
7 the Brookings Institute or others, these are organizations
8 that are thought leaders, and we need to be influential.

9 Those organizations can help convene the advocacy
10 organizations and consumer organizations, and empower that
11 voice in a way that doesn't happen independently. We already
12 mentioned the philanthropic organizations, the foundations
13 that are interested in this. It is extremely important to
14 have them at the table.

15 I think there has been a fundamental shift in the
16 way that human services are provided. It used to be that the
17 philanthropic community provided the pilot dollars that
18 demonstrated new innovations, and then government would take
19 over what worked. That is not the case any longer. I think
20 foundations are in the position right now, doing the need to
21 influence public policy in the work that they do.

22 Also, the importance of the National Conference of
23 State Legislators and other organizations, the National
24 Judges Association, the National Council of Family and
25 Juvenile Court Judges, who see firsthand the people coming

1 through their courtrooms and the revolving door that they
2 see, and the importance of the successes of the drug court
3 models that are out there.

4 Also, I think mental health is much more fractured
5 in the federal government than is acknowledged. The victims
6 of crime dollars that are in the Department of Justice could
7 be much more effectively applied to trauma and treatment
8 issues. There are other places. Housing; there are dollars
9 within HUD that deal with behavioral health in housing
10 settings. But as long as all of that stays fractured, we
11 don't get to have a comprehensive policy or have the right
12 people at the table for these discussions.

13 So I think SAMHSA can play a very important
14 convening role in that.

15 MS. HUTCHINGS: And the last word.

16 DR. HUMPHREYS: Whoever said need to generate real
17 data, I want to applaud their optimism that real data is what
18 moves policy, as opposed to the fake data that usually seems
19 to drive things.

20 As a practical strategy though in terms of real
21 data, Robert Wood Johnson has an initiative, I think it is
22 called Prism, that they share with the Research Institute in
23 Philadelphia, which is headed by Tom McClellan. They are
24 commissioning physicians to do reviews of how addiction
25 affects things other than addiction.

1 In other words, if you treat sleep disorders, here
2 is how much easier their life would be, not to our agenda,
3 but to their agenda. You could treat sleep disorders much
4 better if you recognized and treated how many of your
5 patients had problems with drugs and alcohol. They have one
6 for cardiac care. They are producing one for diabetes as
7 well.

8 It is already there. It is just a matter now of
9 all of us going out and saying, my agenda and your agenda is
10 the same thing. Here is the evidence. You will have lower
11 health care costs, you will have better outcomes in the
12 things you care about.

13 MS. HUTCHINGS: Are you hungry? Do you want to
14 break? One more point, one and a half points.

15 DR. WANG: Just a quick comment. At least at the
16 state level, what I have seen for the past number of years is
17 that part of it is the difficulties in connecting people
18 together in a very powerful group.

19 Every state has a mental health planning council.
20 In our situation, because of the Medicaid lawsuit we have
21 also a child behavioral health council that are very, very
22 active right now.

23 The thing that I have noticed is that people do not
24 really connect together and work together as a whole. I
25 think we have to look at the federal level in terms of SAMHSA

1 as well as how you work with other federal agencies.

2 Partially, it is what is the vision and what are
3 some of the deliverables, so we at the state level have the
4 common language and common vision that can support in terms
5 of what is going at the federal level.

6 Then it is our state job to pull these people
7 together in terms of coalitions and so forth. There are
8 plenty of coalitions going on in Massachusetts, but it is our
9 responsibility at the state mental health authority to say,
10 let's put these people together in the planning council, in
11 the advisory council, in all the advisory groups, so that it
12 all feeds into the larger state system, and then getting back
13 recommendations and input and whatever to the federal
14 government.

15 MS. POWER: One of the things that we have started
16 some conversation about at SAMHSA is, what does it mean to
17 position ourselves as a public health agency. I would ask
18 all of you to think about that and to respond to that.

19 If you are going to a website and it says we are a
20 human services agency, we are a social services agency, we
21 are a public health agency, you go across to the Department
22 of Health and Human Services and you will see all three
23 phrases in different operating divisions.

24 So what does it mean at the federal level to be a
25 public health agency? It is very different than what a

1 public health agency in my home state; it is a regulatory
2 agency. It does nothing else but regulate public health.

3 So this whole notion about defining for ourselves
4 at SAMHSA, for our constituency groups, for our partners,
5 what we mean by a public health agency, means that we are
6 shifting Cynthia's issue to a population-based approach. We
7 are shifting to a population-based approach with the three
8 key elements that make up what a public health agency does.
9 I think that messaging is going to be hugely important, and I
10 think it is going to be important and incumbent upon us to
11 share what we think with you, and you resonate back to us as
12 members of the Council, and to test bed that with
13 constituency groups around what that means, because that
14 becomes a key issue in the future.

15 MS. HUTCHINGS: You had mentioned talking in the
16 same language. So my understanding is, there will be a
17 shuttle for you out front, and that will bring you back to
18 the hotel for lunch. We will restart promptly at two
19 o'clock, so if you could be in your seats and ready to roll
20 at two. This will be the topic of conversation, as you know.

21 Excellent jot this morning, excellent input. Thank
22 you very much.

23 (Whereupon, the meeting recessed for lunch at 12:35
24 p.m., to reconvene at 2:00 p.m.)

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14 A F T E R N O O N S E S S I O N (2:00 p.m.)

15 MS. ENOMOTO: I am informed that we do have a
16 quorum and we are officially reconvened for the afternoon
17 session.

18 **Agenda Item: Creating and Sustaining Recovery**
19 **Oriented Systems of Care**

20 MS. HUTCHINGS: You are back. I am so impressed
21 you returned. Let's hit the ground running with the second
22 part of the dialogue. I thought we had a really energetic,
23 great start this morning to our first topic. The second one
24 is creating and sustaining recovery oriented systems of care,
25 something that should be near and dear to our hearts with the

1 work that we do.

2 The materials are in Tab F in your binders. The
3 same framework would apply to the first dialogue that we had
4 together, so tri part. What we would like to see, the
5 visioning, what are realistic ways of achieving that vision
6 within a five to ten year time frame, and this focus on
7 partnerships, internal partnerships with SAMHSA, external
8 with feds and other partners, how the field can partner with
9 itself as well as with others.

10 Just a reminder. We have provided several
11 documents as well that you received prior to the meeting. I
12 appreciate the folks that put those together, the CSAT
13 documents, the working definitions in the places we will be
14 covering, Dr. Clark's presentation on recovery oriented
15 systems of care, and of course the well-known CMS national
16 consensus statement on mental health recovery. That is in
17 the form of a brochure.

18 So this is some quotes from you again during our
19 interviews. You said these things much more articulately
20 than I could, so I just stole your words and am representing
21 them back to you. What we would like to see. This requires
22 huge cultural changes in our mental health and substance
23 abuse systems and other health systems that are now currently
24 geared toward acute care, in terms of gifts the behavioral
25 health field gives to the entire health system, our vision of

1 what is possible should drive overall health and wellness.

2 I heard this from many, many of you. We need clear
3 definitions. How will we know that a system is recovery
4 oriented? Finally, how can we use this as an opportunity to
5 reinforce the need for strengthening integration of mental
6 health and substance abuse into general health. Your words,
7 pretty smart.

8 So focusing on this part of the topic, recovery
9 oriented systems of care, creating and sustaining them. We
10 can make an argument we haven't fully created one yet
11 perhaps. We have made inroads into creating some of them,
12 how are we going to sustain them.

13 Who would like to take a first look at this while I
14 switch AVs? Your vision. Come on, this is our bread and
15 butter. I shouldn't have to pull this from anybody. Who can
16 give me a vision statement?

17 MR. GILBERT: How about a life in the community for
18 everyone?

19 MS. HUTCHINGS: A place in the community for
20 everybody, except ELT members, right? Other thoughts,
21 vision?

22 MS. POWER: I think for so long we talked a lot
23 about how treatment works. I think the vision I have is,
24 recovery works. This whole notion of building recovery and
25 resilience is not just something that is a work in progress,

1 but that we have learned over time that recovery does work.
2 It is a journey, it is a process, it is a healing. I think
3 it has resonance for both mental health and the addictions
4 field, mental illness and addictions field, uniquely
5 applicable as you can see from the material.

6 But I think recovery works, or something like that,
7 that gets us beyond treatment works and prevention works.

8 MS. HUTCHINGS: If that is the case, what
9 implications are there for creating and sustaining recovery,
10 Kathryn? If recovery works, how do you get there talking
11 about creating those situations and then sustaining them?

12 MS. POWER: I think for us, the notion of recovery
13 is hugely important. I and other members of ELT have been a
14 group that say, we bring recovery to the table. We at SAMHSA
15 are the owners and the leaders of recovery. I think of us
16 that way. Therefore, this whole issue about bringing it as a
17 gift to the rest of the health care system is hugely
18 important. That means preaching it, talking it, speaking
19 about it, have consumers and families leading that discussion
20 about what recovery means, because the rest of the world does
21 not understand recovery, does not.

22 The whole issue about defining it and practicing it
23 in systems starts with an explanation and understanding and
24 embracing of recovery. Frankly we have a long, long way to
25 go just to get people to even say the word recovery and

1 believe in it, and therefore expect services that are
2 recovery focused, never mind provide services that are
3 recovery focused. So we have a really long way to go.

4 Now, we started to segment some of those
5 populations by taking on psychiatry, because we think
6 psychiatry needs more attention than other professions about
7 embracing recovery. Or we have taken on other particular
8 segments of the population under the transformation rubric to
9 say we really need to focus on that group because they are
10 the agents who are going to help do recovery. But we have a
11 whole plate of different educational efforts that need to go
12 on in order for people to embrace the notion of recovery, and
13 then bring evidence based practices to that system.

14 MR. STARK: When I think about recovery, I think
15 about the issue of personal responsibility. I really think
16 recovery is an individual's desire hopefully and
17 responsibility, and that we are players in that process. But
18 we are not the responsible parties. We and family members
19 and others, truly if we do things right, can be players, can
20 support recovery, but recovery is an issue of personal
21 responsibility.

22 So what do we do? Clearly we provide treatment,
23 clearly we provide certain support services, but there is
24 also a whole education thing that has to occur. I think we
25 know there are a number of people with chemical dependency

1 and a number of folks with mental illness as well, who for
2 whatever reason don't follow principles that would be
3 positive for their own personal recovery.

4 Again, we can look to health care, to the same
5 kinds of issues around cancer or other illnesses, where the
6 health care system has the potential to move to a recovery
7 model, albeit it slow and challenging. One of the biggest
8 barriers is compliance of the patients themselves, who for
9 whatever reason do not follow the principles initially of
10 recovery. Later on as they begin to see the value of that,
11 then they do begin to follow it, and we can provide some
12 assistance with that.

13 But I truly see recovery as a personal issue, and
14 we really I think have a responsibility to do a lot of
15 education around that, both for the people that we serve, the
16 consumers, the family members and the allied fields. It is
17 not just alcohol/drugs and mental health, it is health.
18 There is recovery from almost any illness. There is a model,
19 there is a plan that can be developed. It is not always
20 about coming in and seeing a psychiatrist or an M.D. or a
21 counselor. It is about a life journey. It is about what you
22 as an individual see as recovery in whatever journey you want
23 to take, assuming you are educated as to what recovery really
24 means and that is the direction you want to go in.

25 MS. HUTCHINGS: So we are two for two with some

1 themes that we heard this morning already being relevant to
2 this conversation as well, about public education. I would
3 venture so far to say we have quite a bit of education to do
4 in our own field still, and one's own responsibility too.
5 Fascinating.

6 MS. HARDING: Journey, Ken, is something that
7 people who live in long term recovery use a lot, so I would
8 go with journey. But for me personally, I always thought of
9 recovery as a process. It is a personal process for health
10 or healthy lifestyle choices or something along the line. It
11 is not a program, it is not really a service, it is a
12 lifestyle choice.

13 I don't like the word responsibility at all in
14 anything that we do when we talk to substance abuse and
15 mental health. But I would yield to that. But a process or
16 a journey of someone's personal choice is for me closer, and
17 more importantly for people that I work with in recovery.
18 Those are the kind of things they talk about. It is like
19 living with another health care issue.

20 I believe that the vision for SAMHSA in my opinion
21 is that we need to help bring the services that people in
22 recovery need when they need it and where they need it.
23 That is kind of a litany of a lot of different types of
24 services, depending upon the individual's choice.

25 MS. CUSHING: Just to expand on what Francis and

1 Ken said, in thinking about recovery and being focused on the
2 individual, and that ultimately the responsibility lies with
3 them, there is a responsibility that lies within the family,
4 the community, their workplace, the environment in which they
5 function, that can be subtle, that can be a positive
6 influencing factor in so many ways; how flexible is the
7 workplace, how understanding and educated is the family, what
8 kinds of other support systems does that person have. They
9 don't just function in their own world or in their recovery
10 group; they live outside those groups as well.

11 This education that everyone is speaking of is
12 tantamount to that. The more people understand and have
13 confidence in recovery and that recovery is possible, the
14 more they will be willing to wrap their arms around that
15 idea, and there can be a cultural shift around recovery.

16 We have done a lot of shifting in our culture
17 around our thinking and our ideas about lots of health
18 issues. You think back not that many decades, and the idea
19 of AIDS was, oh my gosh. So if we begin to change the
20 conversation, begin to educate the public and the mindset,
21 the world and the environment in which the recovering
22 individual is functioning can be incredibly supportive.

23 MR. BRAUNSTEIN: I would like to suggest another
24 view of this, and a view of it from the standpoint of both
25 broader issues but also the business we are in.

1 Recovery essentially makes good business sense,
2 because people who do better self care cost less to serve.
3 It creates greater capacity in the system. Furthermore, I
4 see as one of the major challenges that I face that it is
5 very hard for providers of episodic care, which includes
6 psychiatrists and others who are involved in that kind of
7 service system, to let go of the fact that they are no longer
8 the central focus of the system that we have.

9 But I think it is a lot easier to sell when it is
10 also identified in a vision statement, that it is not just
11 the actualization of the individual, it is the system
12 creating greater capacity and the system finding efficiencies
13 even within its service system itself.

14 MR. ALEXANDER: Every time I hear recovery, I think
15 about a nine-year-old kid who has been in foster care and has
16 been moved to 24 different homes. They can't develop
17 attachment. They go to school, there are issues at school,
18 there are issues in the community because they moved 24
19 different times.

20 So what do we expect young people, children, to
21 recover from? To what extent do they have personal
22 responsibility for their recovery? Or is it the adults in
23 the community responsibility to enhance their resilience?

24 So when we talk about recovery oriented, in
25 children we want to think about those things. This nine-

1 year-old did nothing wrong. They don't have anything to
2 recover from. It is the sick adults in their life that need
3 to recover. So resiliency is also a thing, how do we create
4 resiliency informed systems that are recovery oriented.

5 MS. HUTCHINGS: Excellent point, excellent.

6 DR. LEHMANN: This is very much a continuation of
7 the conversation we had this morning. For one thing, the
8 recovery concept is a major route toward destigmatizing
9 illness of any kind.

10 The other part of it is though something you were
11 both talking about. Part of the message is, you can do it,
12 but you may not necessarily be able to do it alone. It has
13 to build on the sense of community, which means that your
14 clinician providers have to believe you can do it, your
15 family has to believe you can do it, and you have got to
16 believe you can do it, but sometimes you may need more help.
17 The individual in the depths of psychosis may need that
18 psychotropic medication to get themselves back on their feet
19 and then understand what that medication has done for them,
20 and then realize their trigger signs or warning signs when
21 they increase a dose or when they need it. That keeps them
22 out of the hospital. I have seen that happen, I think we all
23 have.

24 So is it that combination message, and it is very
25 much tied to the public health role of SAMHSA and all the

1 rest of it, its colleagues, to get that message across,
2 whether we say treatment works. It is just another way to
3 looking at treatment and how people can help themselves.
4 Again, it is exactly the same as it is with diabetes and
5 hypertension. Either you keep to your diet and you keep your
6 blood sugar under control, or you don't. It is the same
7 thing with mental health. Either you do the things to avoid
8 alcohol and take your medications or whatever you need to do,
9 or you don't. That leads to certain kinds of outcomes for
10 you one way or the other.

11 MS. WAINSCOTT: How would we know when the system
12 is recovery oriented? When people recover we don't measure
13 that, mostly. Mostly we measure still how many times to go
14 to the doctor, how many pills they take, those sorts of
15 things.

16 I think the thing that is the essential ingredient
17 for a recovery oriented system is hope. Our systems are not
18 full of hope. Some providers, not all, but some providers
19 lack faith in the capacity of the people that are sick.

20 Certainly we do not have payment incentives that
21 work that direction. I think the paradigm shift, I think you
22 called it cultural change, whoever said that I think was dead
23 on. It is a cultural change that has to happen, and it has
24 to happen with providers, it has to happen with family
25 members, it has to happen with the community. I hope we will

1 get back to talking some more about public education, because
2 I think that is a key part of both of the topics.

3 And it has to happen with the people who devise
4 incentive systems. As long as we incentivize keeping
5 somebody in a room doing what I call macaroni therapy, that
6 is what is going to happen. If we incentivize them getting
7 out into the community, then that is what is going to happen.

8 MS. HUTCHINGS: So part of what you are advocating
9 is less process measures necessarily and more outcomes based?

10 MS. WAINSCOTT: Yes, absolutely. But when I think
11 about the vision, you do have to have a system -- and it
12 keeps coming up around the table -- that pays for the right
13 thing. As long as we pay for the outcome we don't want, we
14 are going to get that outcome.

15 MS. HUTCHINGS: So Mark's vision from earlier.

16 MS. WAINSCOTT: Right. But the other thing that I
17 think is much harder to put your hands around is the hope
18 part of it. That has to do with expectations. That has to
19 do with patient centered care. That has to do with letting a
20 person make their own choices. A person who is non-
21 compliant, who is by definition not following a rule that
22 somebody else gave them, take that medicine, by definition
23 that is what non-compliance is.

24 Well, to the degree that we let people into that
25 process, they are much more apt to get adherence to the

1 routine, and health.

2 MR. STARK: I would also argue that it really
3 depends on who you are trying to sell to.

4 MS. HUTCHINGS: Who should it be sold to?

5 MR. STARK: Yes, who is the audience? If we are
6 trying to sell recovery to the local business people, for
7 them recovery might be defined as, nobody in the community is
8 ripping off their store anymore. If you are trying to sell
9 it to the health care managed care company, it may be that
10 recovery is defined as, the person is not revolving in and
11 out of the hospital emergency room, which bills they have to
12 pay, anymore.

13 There really is going to be a significant across
14 the board different viewpoint if you will of what recovery
15 means to different organizations. Consistent with our
16 discussion this morning about, what do I care? If I am an
17 advocate and I am trying to get some support from different
18 folks, I don't necessarily care whether the folks I am
19 looking to get support from, whether it is a fiscal
20 conservative or whether it is a liberal, I don't care what
21 their reason is to support what I am trying to push, what I
22 am trying to get is their support. So I am going to try and
23 push it i a way that is going to meet their agenda.

24 Even though we are looking at coming up with some
25 definitions for us, which fits our agenda, I'm not sure I

1 would use those same definitions if I went out and talked to
2 the Kiwanis Club or other folks. I would probably use very
3 different verbiage, and I would focus on very different
4 measures, if you will.

5 MS. ENOMOTO: With respect to how would we know if
6 the system is recovery oriented, I guess it is tooting our
7 own horn, but I think the national outcome measures do help
8 us know that.

9 It is when a child stays in school, when someone
10 has a stable place to live, when people are able to get jobs
11 and not be in the criminal justice system. In fact, if we do
12 a good job of collecting the NOMS, we can use that data for
13 different audiences. We can use that for business owners for
14 reducing crime, for reducing the burden on the CJ system. We
15 can use it for educators for keeping kids in school, making
16 sure they are staying on grade level, things like that.

17 So i na way, I think this was part of the visioning
18 of creating the NOMS was very much in line with knowing when
19 we had a recovery oriented system of care. Getting there is
20 challenging, to be able to collect all that data, but I think
21 it is there.

22 One of the messages, in addition to recovery is
23 possible, is also that recovery is not an accident. It is an
24 effortful process, whether it is a personal responsibility.
25 Someone today said they have a relative with diabetes, and I

1 said, that is a lot of work for you guys. It is just
2 automatic. When someone says diabetes, that is a lot of work
3 for the individual, for the family. We know that. It takes
4 effort to manage that and maintain health. We need to make
5 that parallel, so that when someone says, I am in recovery,
6 that is a lot of work for you, for your family. It is not
7 bad work, it is just the work we have to do to maintain
8 health and not just be focused on recovery, but also wellness
9 in addition to resilience.

10 MS. HUTCHINGS: The conversation seemingly so far
11 imparts the notion that recovery being specific to quote only
12 mental health and substance abuse fields. Is there anything
13 that precludes using Kana's points of NOMS and those specific
14 measures to influence other fields that are health related
15 fields and what makes healthy communities and healthy people?
16 Is there a vision that comes from one of you about that,
17 outside of our own two fields specifically?

18 MS. WAINSCOTT: Yes, if you use the word wellness,
19 and if we become part of the whole concept of wellness, you
20 begin to move toward that.

21 MS. HUTCHINGS: So what does that say about, if you
22 can create it in the first place, how would you sustain
23 recovery in our systems and other systems? How do you do
24 that? Daryl, you had mentioned earlier, it is not about
25 always funding the same old grant over and over again. How

1 do you get to that culture change? By the way, I am not
2 giving a lot of attributions, but that was Dr. Cline's
3 cultural change comment that you had asked about.

4 DR. HUMPHREYS: I think a huge part of it has
5 nothing or very little to do with treatment, but has to do
6 with society making places for different sorts of people.

7 One of the things that the United States stands out
8 as, unlike any other country in the world, is the number of
9 peer support organizations there are for literally every
10 single diagnosis, not just mental health, across the board.
11 I think the last data is, one out of 14 Americans will go to
12 a self help group for something at some point in their life.

13 Those settings end up being very important in the
14 sense for people being able to be understood, but also to do
15 the same kinds of things everybody likes to do, like talk to
16 other people and have social events and have a life. No
17 matter how good a health care provider you are, you can't
18 really give that to everybody. You can't be everybody's
19 friend. It would be unethical and you don't have time, you
20 have new people coming all the time.

21 So that to me is the great de facto part of our
22 care system or our recovery system that we are blessed to
23 have, that makes all our work easy.

24 I will end this long speech by saying, to the
25 extent that what we can do who work in health care, that

1 should be part of the care of every single patient for every
2 single chronic disorder, not just ours, that their care
3 providers know about these organizations and tell them where
4 they are and what they are, but not make them go but let them
5 know they could go, and they should at least give it a try
6 and see.

7 MS. HUTCHINGS: You did just what I was going to
8 ask you to do, so thank you, that linking.

9 MS. POWER: Building on a couple of the thoughts, I
10 think if we were going to influence other care systems
11 including our own, because I started the discussion thinking
12 about our own systems that we influence, but this whole issue
13 of generically trying to get to the healthiest nation, which
14 is CDC's latest public health approach.

15 If we were trying to apply the recovery principles
16 to how would we get to the healthiest nation, we would start
17 off with the issue that Cynthia raised, and that is
18 hopefulness. that everything in our health care system should
19 be geared toward building hope and hopefulness.

20 If you read Jerome Gutman's book and you start to
21 lay out every single tactic and strategy that you would put
22 in play in a health care system that was imbued with hope,
23 you have got a strategy there.

24 Then the second level is that we need to be
25 universally trauma informed. That was raised this morning as

1 well. What is nested in the health care system broadly is
2 trauma, not just in our health care system, but everywhere.
3 So it needs to be trauma informed.

4 Then the third level would be insuring that those
5 evidence based practices and emerging practices and best
6 practices can build to a sense of and a process of recovery
7 and resilience, which would include some of this public
8 educational effort that should be going on about building
9 competencies through a life span approach. Then you have a
10 solid way in which you can measure a level of recovery that
11 is being achieved by the individuals who happen to come into
12 the health care system for those kinds of services.

13 MS. WAINSCOTT: I see his happen all the time. It
14 happened last week. I got a call from a family that was at
15 their wits' end with their child. They had been fighting
16 this for three years. They were against the wall. The
17 justice system was involved, et cetera.

18 You know what made it better for them? Talking to
19 another family who had been through it. I don't know if they
20 even gave them any advice. They were just there for them.
21 You could hear the tension go out of their voice.

22 What I wanted to say though was, when I think about
23 a vision, continuity is part of what is missing. The
24 episodic nature of the way we do things works against
25 recovery. We have got to get continuity going better than we

1 do. That is something we can learn from the rest of health.

2 Can you imagine, if you have got a heart problem,
3 and you go to five different doctors and five different
4 visits? That wouldn't happen to you. It works better not to
5 do that. The episodic nature is a danger.

6 So I guess a positive part of the vision is
7 continuity of care.

8 MS. HUTCHINGS: Terry, if I could ask you, I was so struck
9 during our phone interview, and grateful, you had been so
10 articulate about what society values in talking about
11 cultural perspectives on what gets valued and how that gets
12 played out in terms of policy. Can I ask you to contribute
13 some of that?

14 MR. CROSS: I hope I can remember. I was just
15 sitting here. This is kind of a challenge to kind of make a
16 cultural leap because this whole notion of recovery is
17 defined differently in different cultural paradigms. In
18 American society and much in European society, it is very
19 individualistically oriented paradigms. The notion that the
20 individual owns the problem, that this personal
21 responsibility issue, the whole idea of stigma is tied to
22 this being a personal failure.

23 In tribal cultures and indigenous culture, the
24 notion of a problem with something, whether it is mental
25 health or with substance abuse or any other problem, it

1 doesn't belong to the individual. It is simply things out of
2 balance. So recovery is coming back into balance and
3 maintaining that balance.

4 It is your natural state of being. So when you
5 come to recovery you are coming home to your way that you
6 were created to be. So there is a spiritual cultural
7 dimension to that defining.

8 There is not nearly as much stigma in tribal cultures about
9 recovery.

10 As a matter of fact, I have 22 years of
11 sobriety. When I say that in a non-Indian organization, a
12 conference or something, there is almost always silence. It
13 is like, you are not supposed to talk about that. When I say
14 that in an Indian gathering, people stand up and applaud.

15 We have a joke about, when you get a DWI you get
16 your name in the paper but when you go to treatment that is
17 confidential. What is wrong with that picture? Why should
18 we be so secretive about something that we should be
19 celebrating, that somebody is willing to get that help?

20 If going to treatment and getting into recovery is
21 not about you and your personal failings or personal triumph,
22 it is about coming back into this balance that is a natural
23 state of being, it is a much easier state to be in. It is
24 easy to embrace that. It is easy to share that with other
25 people. In our culture, sometimes the person who has had the

1 meanest life that you can imagine ends up getting into
2 recovery and can be a trusted community leader, given stature
3 because of the nature of their capacity to recover and to
4 help other people.

5 So I said here, what can I offer to this
6 conversation, because it feels like the paradigm is caught in
7 the cultural constraints of American society. I'm not sure
8 how you get out of that. For many, many of the people that I
9 know who are in recovery, there is such a strong spiritual
10 and cultural dimension to that recovery, that I think it is
11 hard for systems to embrace that, particularly when it is
12 taboo to talk about the spiritual nature of that recovery.

13 I also don't know how we count the numbers, when we
14 have so many people who are going to AA and who are living in
15 recovery through self help models, and never touch the
16 treatment systems.

17 MS. HUTCHINGS: So the answer to your question; you
18 just contributed what you were wondering, so thank you.

19 MR. STARK: When I used to work for the Department
20 of Social and Health Services, which is a conglomerate mega-
21 agency in Washington State, they had a mission
22 statement/vision that I thought was pretty neat, and I still
23 think it is pretty neat today. That was, working with
24 individuals, families and communities to achieve a safe, self
25 sufficient, secure and healthy life.

1 You can take each of those words, safe, self
2 substance use, secure and healthy, and segment that down into
3 a whole lot of different things that would define recovery
4 from an individual, a family or a community standpoint. I
5 still like that today, so I think in that term.

6 MS. KADE: Just to comment on, you don't know how
7 to count them. When we were deliberating and developing the
8 data strategy one of the issues is that we do count
9 incidents of prevalence in terms of who is in need of
10 treatment and who is not getting it, and we weren't counting
11 the people who were in recovery, and showing the large number
12 and showing that it was growing over time.

13 One of the issues was, how do you define it, if you
14 had that number and you showed it was growing and your
15 vision, that it would keep on growing, that is a very
16 powerful theme.

17 MS. HUTCHINGS: Can we go back to this lingering
18 question about, have we defined recovery already, have we
19 defined it for mental health only, have we defined it for
20 people with substance abuse issues only? Should there be one
21 recovery statement and a consensus among the two fields of
22 what that is? Should it be different definitions for
23 different audiences, part of Ken's point about who you are
24 trying to influence?

25 There is no group like this one that can help give

1 input to shape for where SAMHSA might go, what are some of
2 the steps to help answer these questions, definitions.
3 Thoughts on that?

4 DR. HUMPHREYS: I think there is a limit to how
5 productive it is to define it. In fact, maybe to say it
6 another way, there can be some damage done by defining it too
7 well.

8 Most movements have terms and concepts that are
9 kind of gauzily defined, but they let everybody sign on. At
10 the height of the civil rights movements, there were terrible
11 factional disagreements about certain terms, justice, human
12 rights united people. If they had sat down and said, what do
13 you mean by that exactly, they might have started fighting
14 each other, and they had better things to do; they had to
15 fight the whole society.

16 So I think recovery, there is tremendous
17 disagreement among mental health, among addiction, between
18 them both certainly, that are productively avoided by us
19 having this vision globally, but slightly gauzily laid out,
20 so that different people can grab hold of a part of it and
21 not feel excluded in any way. That may be the level that it
22 needs to be defined, and not any more than that, because when
23 it gets too detailed, then people say, I guess I am not
24 actually a part of this after all.

25 MS. HUTCHINGS: Can I ask, how would one be able to

1 embrace that, so don't get too anal about this, let's let it
2 out there, let more people sign on where they can find a
3 place for themselves, at the same time knowing you need some
4 ability to measure something in order to get OMB not opposed
5 to you? How do you reconcile those two needs?

6 DR. HUMPHREYS: I don't know if they can be
7 perfectly reconciled. There is a basic contradiction between
8 demonstrating that you have spent federal dollars well and
9 then letting people do lots of different -- one possibility
10 is, you gave a lot of flexibility in process and worry about
11 outcomes.

12 In the addiction field, everybody can agree, I
13 don't want my life to be destroyed by drugs and alcohol.
14 What they can't agree on is how I am supposed to get there.
15 But that may be totally unimportant. So one person can do it
16 with their AA, another person with the Women for Sobriety,
17 another person through going to a hospital, another one with
18 a medication, another one through a faith group, that kind of
19 thing.

20 That is where you say, we don't define any of that.
21 You define it. It is a diverse country, pick your path.
22 But in the end we will still be able to say, there is
23 something we do all agree on, we don't want lives destroyed
24 this way, so that is what we will measure.

25 DR. WANG: I just have a very short comment. I

1 think this is a very difficult question. I struggle with it
2 in terms of even the term recovery, translating it into a
3 couple of languages and looking at different cultural groups,
4 how do they look at the word recovery itself. I couldn't
5 even find it specifically in Chinese, the term recovery, what
6 that exactly meant.

7 The only thing I wanted to say is, to me recovery
8 is the process and wellness is the outcome. I try to use
9 some examples, someone saying, I have financial difficulty.
10 The recovery is the financial wellness of that individual,
11 community or families.

12 I know that it is a little bit simpleminded, and I
13 think that still needs some definition, but for me, it is
14 that recovery is the process, wellness is the outcome, and
15 let different groups and different systems define what that
16 means, but with some parameters.

17 MS. HUTCHINGS: Mark has got that one jotted down.

18 MR. BRAUNSTEIN: To do this in a simplistic way, I
19 would tie it to our discussion this morning and say there is
20 such a thing as mental illness. With proper treatment and
21 support people recover. There is such a thing as chemical
22 substance use disorder and with proper support people
23 recover. I think that you have to tie the two together, just
24 like you would say there is such a thing as heart disease and
25 with proper treatment and then support because can recover

1 and lead normal lives. To get back to Terry's idea, getting
2 back into balance, getting back to being productive members
3 of society.

4 MS. HUTCHINGS: George, can you work into that
5 paradigm wellness, prevention, early intervention? Can you
6 go upstream for me and incorporate that?

7 MR. BRAUNSTEIN: Well, the package that is
8 recovery, the full package of recovery -- and I will use some
9 of the medical paradigms that we take for granted; people who
10 have major cardiac incidents end up having cardiac
11 rehabilitation. They go through a whole series of activities
12 that have to do with learning how to prevent further problems
13 in the future, changing their diet, learning how to exercise
14 and so forth and so on.

15 So if you put that package together in a very
16 similar model, and I know I am sounding very medical model
17 right now and I am not as medical model as I am sounding, but
18 what I am trying to do is simplify something that people can
19 understand, put it in a language outside of our own system.

20 I often have to deal with local and state
21 politicians and local administrative folks who will not
22 understand mental illness unless you put it in a simplistic
23 paradigm that you could then shift to experience they have
24 already had. That would be the example I would give. I
25 think it is very salable that way and I have sold it that

1 way.

2 MS. POWER: I was going to answer your question.
3 My response was going to be that my vision is that there
4 won't be an answer to your question because we will have
5 moved with such a great sense of urgency that it will be
6 eclipsed by the sense of urgency that is brought on that we
7 won't ever have to answer your question.

8 In fact, even in the last five years that I have
9 been here, the orientation about discussions about recovery
10 is more and more closely aligned even as we speak. It
11 doesn't have to be an exact fit, but it is more closely
12 aligned along the dimensions that Keith talked about.

13 I think if we try to answer that question, we will
14 get hung up on just answering that question and not moving
15 our own sense of urgency to building a more recovery focused
16 issue.

17 I will also add, and it is my personal opinion, if
18 we don't continue to do things like have a recovery month for
19 both substance abuse and mental illness, then we continue to
20 bifurcate and set forward a bifurcation that is
21 inappropriate. So we have to be looking at both of those.

22 My sense is that the movement of the world in terms
23 of embracing recovery is moving, and it is moving faster than
24 we will. We can't slow it down by over defining it, but I
25 think we need to be behind it and pushing it, and hopefully

1 then we will be eclipsing this whole notion of embracing an
2 approach that I think takes consideration of Terry's
3 comments. There is a balance issue, and that balance is that
4 we want to respect the balance that should be a part of
5 everyone's life. That is recovery, or it is wellness.

6 I think we are going to translate to another level
7 of discourse about all of these issues, so we don't want to
8 stop it by over analyzing it.

9 MS. WAINSCOTT: Gail, if I go back to your
10 question, are the principles of recovery transferable? Can
11 they somehow be a bridge almost with the general medical
12 community?

13 Some of them can, I think. You are going to get
14 into problems with things like self direction. A surgeon is
15 going to say to you, no, no, my hand needs to make the cut.
16 When you get into tuberculosis, some of those things, I'm not
17 sure all of these will translate. But if you talk about
18 wellness, I think they all translate. Again, if we get under
19 the rubric of wellness, all of us, then I think it will work.

20 DR. HITCHCOCK: So we are back again to some of the
21 public health approaches to some of this as well.

22 Are we ready to move to the next part of the
23 conversation?

24 DR. GARY: I just wanted to pick up on what Cynthia
25 said about the superordinate concept of wellness and where

1 that takes us.

2 I think when we talk about wellness, or we want to
3 talk about recovery or resilience or whatever, I think we
4 have to also remember that individuals have different levels,
5 different signs and symptoms of illnesses at various times in
6 their lives. Even though they might be in recovery or might
7 be at a wellness state, we have to look at how the system can
8 accommodate them.

9 Now, I am looking at George's comment about a
10 person who is in cardiac rehab. Chances are that person
11 still has contact with the health care provider. In many
12 instances that is not the case with people who have mental
13 illnesses. They couldn't tell you who their provider was,
14 even though they have been in a recovery model or they have
15 been in peer groups or whatever.

16 So I would like to make a very clear statement that
17 recovery or wellness is on a continuum. At any given time an
18 individual might need some other intervention, acute care,
19 medication, crisis stabilization, balance, et cetera. The
20 system has to be able to provide that without somebody taking
21 a week to find some health care for the individual, which
22 frequently happens in mental health care and also in
23 substance abuse.

24 So we have to look at how the system needs to be
25 redirected, how it needs to be re-engineered, in order to

1 allow the implementation of recovery and wellness.

2 MS. HUTCHINGS: So a sustainability issue. When
3 you say the system, what does that mean to you? Is it mental
4 health and substance abuse? Is it health care overall? Is
5 it health services overall?

6 DR. GARY: I think the health care system as
7 defined by the Institute of Medicine. It is the entire
8 health care system. For an example, an individual with
9 mental illness could also have cardiac problems, could also
10 need to see an orthopedist or need surgery or also need to
11 have an adjustment with the psychotropic medications.

12 So I am talking about the health care system to
13 include those social support systems that we talk about when
14 we are discussing the social determinants of health. I am
15 talking about housing, food stamps, SSI. That is the system
16 I am talking about. It is a very broad and messy system, but
17 I think we have to look at those key elements also if we want
18 to have any sustainability.

19 MR. ALEXANDER: Also we need to look at those
20 systems that aren't health care, in my opinion, like jails
21 that become mental health facilities, and juvenile justice
22 systems that become holding places for young people with
23 serious mental health issues. Communities don't have
24 available mental health facilities for young people, or old
25 people.

1 Also, schools. I just can't get enough of schools.
2 Even higher ed, we see what mental health in schools, the
3 crisis that have happened at some of our major universities.
4 So health with people, and people inhabit every endeavor.
5 We are everywhere. So this vision of health, I would like to
6 see it not so much a system but more so that we are caring
7 for people who are in schools, who are at work, who are in
8 various stages of life.

9 MS. HUTCHINGS: But individual level, the community
10 level again, the familial level.

11 So we are going to move a little bit again, the
12 same framework as last time. Now we go from some of your
13 visioning into what you see as some realistic, pragmatic
14 strategies that could be played in the next especially five
15 to ten years.

16 Through your quotes again, SAMHSA needs to position
17 itself as a leader of recovery. We are the most visible
18 entity to lead recovery. SAMHSA staff should discuss with
19 the National Advisory Council what it means operationally to
20 move to recovery oriented systems of care. We are the models
21 for this. Do the outcomes of SAMHSA funded programs make
22 sense under recovery or in a system.

23 Again, not only is this a conversation about input
24 for SAMHSA specifically, but for the fields, what we would
25 like to see happen. Your thoughts on some of the practical

1 ways within this time frame, midterm time frame?

2 MS. WAINSCOTT: I guess I would start by saying
3 that I do not believe that in Georgia the community peer
4 support system would have happened without SAMHSA's support.

5 It got started because we had a Medicaid director who was
6 willing to take a risk on it. The SAMHSA support of it is
7 what made it move.

8 So the answer to the last question for me is, there
9 is one place that it was in spades successful at pushing
10 recovery.

11 MS. HUTCHINGS: So is it part of your point that
12 SAMHSA has an imprimatur that it should be cognizant, that
13 being part of NRAP means something to others? Am I getting
14 that?

15 MS. WAINSCOTT: Exactly, thank you.

16 DR. HUMPHREYS: I am going to go back slightly.
17 What Kathryn said was helpful to me. I should have also said
18 this when you were asking about how do you do your OMB work
19 and also have recovery.

20 Just as treatment is not an individual's recovery,
21 SAMHSA is not the recovery movement. There is a whole
22 cultural aspect to this that the federal government can't
23 control, I hope. I think SAMHSA has done a beautiful job. I
24 was on the planning committee for the big recovery meeting
25 that CSAT put on. It was wonderful to see that. It was

1 clear that SAMHSA had a facilitating role, but also a number
2 of people there said, in the history of the United States no
3 social movement has been started by a federal agency. In the
4 end it has to take on at some level in the culture. I think
5 that it is.

6 So it may not be possible to lead recovery. It may
7 be that all the midwifing that SAMHSA has done and the
8 nurturing and the other parts of the government have done to
9 spawn these organizations and these leaders, they will run
10 off their own way, and God bless them. We will see where
11 they go, and it won't be controlled by us.

12 MS. HUTCHINGS: Just before you said the word
13 control, I was getting there, so to be willing to let some of
14 that go in order to see it keep growing and moving.

15 MR. STARK: I would agree with Keith's statement,
16 but I also agree that a role that SAMHSA can play is both
17 facilitative as well as some significant work around
18 training, training around leadership kinds of activities for
19 peer movements as well as professional.

20 When I think about a lot of recovery services, some
21 of those recovery services are services that, yes, maybe
22 health plans and Medicaid and government funds should pay
23 for, but some of them are volunteer kinds of movements, not
24 unlike AA, Alcoholics Anonymous, Narcotics Anonymous and
25 other kinds of self help groups.

1 But that isn't to say that the agency can't play a
2 role in helping develop leadership and helping train folks on
3 how to facilitate and bring people together in their local
4 communities. I know that SAMHSA has done in the past, is
5 doing it now, and can continue doing that. Maybe it is to
6 look at some very focused kinds of leadership training
7 models, particularly around peer support.

8 One of the things that -- when I was in the mental
9 health transformation project that I was frustrated with was
10 trying to get movement to looking at a whole lot more peer
11 and family support kinds of services. Fortunately there was
12 a piece of legislation passed in Washington State where the
13 mental health division in Washington State is now working
14 with folks to try to develop a plan, but where SAMHSA could
15 help Washington State would also be to -- and I imagine a
16 number of other states, would be to try to identify where are
17 there some best practices, some centers of excellence if you
18 will, and help pull that together and share that with folks
19 in other states.

20 That isn't to mean that a state when given good
21 information is going to implement it, because we all know
22 there is -- as Kathryn said earlier this morning, there are
23 issues of leadership, there is issues of timing. That will
24 all come up. But clearly there is a role for SAMHSA to
25 facilitate, to train around leadership, that sort of thing.

1 MR. GILBERT: Ken and Keith addressed what I wanted
2 to talk about a little bit, and that is this notion that we
3 need to position ourselves as a leader.

4 I agree, I think it is very difficult for SAMHSA to
5 position ourselves as a leader, because certainly for CSAT,
6 our involvement in recovery and recovery oriented systems of
7 care was in direct response to the field coming to us and
8 saying, you need to be aware of what is going on out here,
9 and you need to figure out how you can help us move this
10 along.

11 So I agree with Ken. What I think I am really
12 interested in is finding out what are the roles that SAMHSA
13 can do to build on this momentum that is growing outside of
14 SAMHSA. What we found over the last two or three years, as
15 we have attempted to take the message from the national
16 summit on recovery, we have begun to get some feedback that
17 says, this is the new SAMHSA mandate, recovery oriented
18 systems of care. Not our intention at all, but you can see
19 how if we are not careful, we may start turning people off
20 instead of encouraging what we are looking for and finding
21 out what our proper role is to support what is already
22 happening out there.

23 MS. POWER: I think we have to be a leader and a
24 facilitator. For me, the leadership rests with the groups
25 like the federal partners and the groups like the Federal

1 Executive Steering Committee. I think if we don't speak
2 recovery, nobody else is going to speak recovery. In that
3 sense I think we have a leadership role.

4 I think that it is very important that when we talk
5 about recovery, we are talking about the whole gamut of
6 promotion and prevention and treatment, so that is our whole
7 recovery message. So the leadership role for me includes
8 facilitation, but it is a statement. It is a statement to
9 the states, it is a statement to our federal partners, it is
10 a statement to constituency groups that want to know where we
11 stand, and if we stand solidly on a leadership position for
12 recovery, I think that is important.

13 I will also note that the lovely board of directors
14 that gives us all this money, we have one program with the
15 name recovery in it, and that is ATR. I have a whole
16 portfolio of 37 programs and recovery is never mentioned in
17 any of them. It is not that it is not mentioned, but that is
18 not the way the funders see us. So we still have a
19 leadership role to play, to say what are the outcomes and why
20 do we exist, to convince the Congress and OMB and others that
21 we are driving to achieve better life for people, and it
22 includes the process of recovery.

23 We should be facilitating that to every single one
24 of our programs that we have, whether it is called
25 homelessness or suicide prevention or whatever the case may

1 be.

2 DR. GARY: I wanted to follow up on what Ken and
3 Kathryn had just said. One of the things that we have to
4 consider is again the assets that SAMHSA has. I think we
5 need to enumerate what they are, not now, but I think that
6 needs to be done.

7 When I was thinking about assets, I didn't think
8 about budget, but Miss K. did, a three billion dollar budget.

9 So how do you couple leadership, collaboration, partnership
10 and your budget to make the changes that you want to at the
11 micro level, the macro level, the federal government level?

12 So I think when we layer them out, and when we look
13 at how we can leverage what it is we wish, we are paying for
14 it. And if we are paying for it, it seems like to me we
15 could design it so that we can get the desired outcome that
16 we wish.

17 So I think that we start from how we design the
18 RFAs, the program announcements, what we want from them, and
19 train people in the local community to be responsive to that,
20 to understand where we are trying to go. I didn't hear much,
21 but I loved the concept of the policy academies that Kathryn
22 mentioned earlier, but to utilize all of the resources that
23 we have at the local level.

24 I would think that SAMHSA has visibility at the
25 local level as much as or more than most federal agencies.

1 It is a sustained kind of relationship. So I think we need
2 to look at our sustained relationship, come back to the
3 concept that Ken always uses, and that is training. Train
4 people so that they can understand how to respond and what it
5 is that we wish to accomplish. We make them our stakeholders
6 which is a word that I think we need to add to this
7 conversation. We need to strengthen our relationship with
8 our stakeholders or in these local communities. Then I think
9 we could lay out the framework and we could get the desired
10 outcomes that we wish.

11 DR. HUMPHREYS: Everything that has been said I
12 think is excellent, about what SAMHSA can do. The other
13 leveraging thing I'll quote. Secretary Leavitt came out to
14 Stanford -- it turns out his younger brother is a med student
15 at Stanford -- right after he was confirmed. I asked him,
16 what can you actually do as a Secretary? He said, if nothing
17 else I am a convener of stature, which I really liked.
18 Meaning, if he sends invitations, people will come.

19 That is true of SAMHSA. The summit that CSAT
20 organized, there were people there, pretty important people,
21 who would never have cause to get in the same room, from very
22 different organizations, including organizations that might
23 have fought with each other most of the time. They did their
24 SAMHSA business. The lunch was important, but evenings were
25 important; people were talking, they were planning, they were

1 putting things together.

2 In that case, that convener of stature is something
3 that could be exploited. Something like that summit could be
4 done again, perhaps including mental health and substance
5 abuse people in the same room, God forbid; give it a try.

6 But anyway, I think it is another leverage point.

7 MR. CROSS: I think what I have to say would jump
8 off of that. I think SAMHSA does a really excellent job with
9 social marketing and some of the media work, but I think it
10 is an area that could be leveraged big time.

11 Some of the ways that you change the outlook of
12 society in general is by having a national conversation.
13 That convener role could be very important, something like a
14 White House conference on this issue and getting good media
15 attention, having media spokespersons, people who general
16 society listened to, and the ability to consult with and to
17 influence screenplays and what Hollywood is doing with this
18 issue. Those are all areas that SAMHSA could leverage
19 further its media involvement.

20 MS. HUTCHINGS: Fran and Judy in particular, what
21 is a way that we could develop some of these strategic
22 activities, using anything from the FTF grants in states down
23 to DFC grantees at the community level? Are there ways that
24 -- whether it is the balance message and bringing that
25 forward, whether it is some of the others? Are there

1 thoughts that have been turning in your mind as you hear some
2 of this? You can feel free to say, not yet.

3 MS. CUSHING: I wanted to say amen to what Terry
4 had just commented on. I think that elevating the
5 conversation and the exposure about recovery and recovery
6 initiatives, the conversation is critically important. I
7 think often we forget the voice of the community, the voice
8 of the citizen, the parent, the business leader, the
9 minister, the local mayor, schools, et cetera. Those voices
10 are at the table in hundreds of communities that are funded
11 through the drug free communities programs and in other
12 coalition efforts on subjects we are talking about here
13 today.

14 We haven't yet begun to tap that resource. I don't
15 think SAMHSA has done -- I think you can do a much better job
16 to capture and to engage those citizen leaders in the effort
17 to be the voice and to become knowledgeable.

18 There are large corporations and small businesses
19 across America. Some of them are in larger communities and
20 cities and some are in quite small towns. But there is a
21 divide between what we see. The business community is
22 willing to step up to the plate and want to be engaged in
23 many of these cases. These business leaders have family
24 members who have had mental illness or who have gone through
25 treatment and are in recovery, and what better voice could we

1 have.

2 Obviously I am a little passionate about that, but
3 I do think we are missing the boat.

4 MS. HUTCHINGS: There are 700 ready to roll.

5 MS. CUSHING: Actually it is probably 800, Fran can
6 tell us more accurately, but they are ready to roll. Their
7 role is facilitator engager in the community. They are this
8 neutral body. So let's use them.

9 MR. STARK: I get back to the conversation this
10 morning and teeing off what was just said. There is no
11 reason why we -- and when I say we I am saying the SAMHSA we
12 at this point -- why we could not become conveners and
13 facilitators of bringing the United Ways from across the
14 country together with some of the big foundation funders,
15 along with your federal partners of SAMHSA and SAMHSA proper,
16 along with a number of other groups across a variety of
17 fields, to sit down and talk about a strategy over the course
18 of the next ten years.

19 The housing folks came up with, end homelessness in
20 ten years, and they brought a number of people together. But
21 they didn't necessarily bring all of the different players
22 together. What we could do if we decided we wanted to,
23 we could bring the workforce folks together, along with the
24 United Ways, along with the private foundations and our usual
25 and customary stakeholders. A lot of those other folks are

1 the folks we are trying to educate. A lot of those other
2 folks are also folks who as Judy already said, some had
3 positive experience in that they have had family members that
4 have had alcohol or drug problems or who have had mental
5 illness, and it has been a positive experience in terms of
6 recovery. Others have had a negative experience, so we are
7 going to get those individual differences. But it is still
8 important, ignoring that personal stuff, passionate positive,
9 passionate negative.

10 How is it from a systems standpoint that we can all
11 work together? Because we have got an aging workforce, and
12 we need to have a productive workforce that is beneficial to
13 all of us. How can we be part of that with you? How can you
14 be part of that with us?

15 MS. POWER: I was thinking that if I ruled the
16 world, I would like to create a program or a set of resources
17 that we could go out and advertise or select certain regions
18 or certain areas that might have a high prevalence and
19 incidence of mental illness or addictive disorders, in a
20 small, medium and large sense, and have categories in which
21 these would be called, go forth and create a recovery
22 oriented system of care.

23 I got the thought, Ken, when I was talking to you.
24 Ken is moving from the transformation at the state level
25 into a county based program, where all those things come to

1 bear at the county and local level in terms of delivering
2 them.

3 I think we have pieces of what recovery oriented
4 systems of care look like. We have SPF grants, we have ATR
5 grants, we have some transformation grants. We don't really
6 have, I don't think, except for maybe some selected states or
7 selected regions, a really concentrated comprehensive
8 recovery oriented system of care. I just don't think it
9 exists.

10 So I think each of us come at this discussion about
11 what kind of resources and what kind of things can I use, how
12 can I facilitate, convene and do whatever it is I need to do,
13 to move this forward. But if I ruled the world, I would set
14 aside some resources and say I am going after the river
15 valleys. You go down the river valleys and you see pretty
16 high incidence of substance abuse and mental illness. Maybe
17 we try a small, medium and large region and we say, go forth.
18 Here are infrastructure and services dollars, go forth and
19 do a recovery oriented system of care. I think that might be
20 a wonderful way if I ruled the world.

21 MS. HUTCHINGS: It is part of that dynasty of
22 yours. Do you believe there are models that exist now?

23 MS. POWER: Oh, I definitely think so. We have
24 learned a lot from the community coalitions in substance
25 abuse prevention. We have learned a lot from the voucher

1 program in Choice and ATR. We are learning from the
2 transformation states about the kind of infrastructure
3 changes. I think there is a lot out there.

4 I think there is absolutely -- we are progenitors
5 of half that information here just at SAMHSA, never mind the
6 rest of the world. I think there is tons of information that
7 people could use to make that happen.

8 MR. BRAUNSTEIN: I do like that idea, because it
9 goes towards what I was going to make a comment on. As you
10 reach further out beyond people who use words like recovery
11 and have some understanding what it means, we need a little
12 bit better definition when we are going to bring in non-
13 mental health, non-substance abuse professionals into the
14 scene and get their support. What does that mean? It is
15 about people living in the community. Well, what?

16 I think with the idea that you just put forward,
17 that will get better defined. There will be models out there
18 that people can buy into, because it really is a community
19 kind of a program.

20 I support all the comments that were made about
21 SAMHSA being the convener and the supporter, the developer of
22 capacity in the community, the encourager, the cheerleader.
23 All those things are what SAMHSA can do because of its
24 position.

25 MS. HUTCHINGS: George, you have actually run

1 frontline programs. How much of SAMHSA's leadership
2 statements come down to a program administrator, to your
3 staff? Penetration of that influence.

4 MR. BRAUNSTEIN: Somebody made a comment that
5 SAMHSA is one of the few federal agencies that people know
6 what it is right away, and not just in our field. Other
7 local government people know what SAMHSA is. A lot of them
8 didn't know what CMS is unless you said Medicaid. A lot of
9 people don't know any number of other federal agencies that
10 have even more effect on some of the policies that have
11 nothing to do with mental health. But they do understand
12 what SAMHSA is, partially because of the grants that have
13 consistently brought forward and built capacity in the
14 communities, partially because the best practice and evidence
15 based practice information that has come down. Those are the
16 strengths that SAMHSA brings forward.

17 Part of my comment about the whole idea of building
18 this around making this a business proposition as well is
19 partially because of the work that SAMHSA has done. I began
20 to clearly understand more about recovery than just the
21 words. At a state level they were just a bunch of words, but
22 some of the materials that SAMHSA has published and some of
23 the examples of how it is used helped me as an administrator
24 understand how to make it come alive more in the system that
25 I am working in.

1 So yes, I think they have an enormous influence and
2 can even use it more so, based on the ideas I heard today.

3 MR. GILBERT: I don't know, Kathryn, what you were
4 thinking of in terms of these grants, how big you think they
5 would need to be. CSAT has started to try to do something
6 along these lines. Last year and again this year, we are
7 funding some small grants through our targeted capacity
8 expansion program, about \$500,000 a year for three years,
9 called recovery oriented systems of care grants. They are
10 designed exactly to do that, to give the community resources
11 to figure out what model do they think will work for them,
12 based on what is known already, and there is a lot out there,
13 and seeing whether or not these communities can develop
14 recovery oriented systems of care to meet the needs of people
15 with substance abuse disorders and co-occurring mental health
16 disorders.

17 We will see. It is a while before that happens. I
18 think the concern that Wesley has had, and he would probably
19 say this if he were here today, and unfortunately he is not
20 able to be here, our concern is that we are going into a
21 period of transition. As Dr. Broderick said this morning, we
22 are going to have a new administration come the end of the
23 year. We don't know who it is going to be.

24 We saw very clearly when we transitioned the last
25 time to a new administration that an initiative that had been

1 developed on the substance abuse side, the national treatment
2 plan, got caught up in that whole transition and got labeled
3 as a product of the previous administration; we are not
4 really interested in that.

5 So his concern has been that we take care not to
6 brand recovery oriented systems of care as a SAMHSA
7 initiative, but that we try to see how we can nurture that,
8 and hopefully with the support from the field, how we can
9 insure that regardless of where we are come January that we
10 have a solid foundation of support from the field to be able
11 to move forward and continue an emphasis on recovery and
12 recovery oriented systems of care, and that it isn't seen as,
13 this is what SAMHSA was doing under the previous
14 administration, we need to move in a different direction.

15 Clearly from our standpoint this has been the
16 strong message that we have heard from the field in the last
17 three to five years, and we don't want to see it get tagged
18 as something that another administration did and we need to
19 change it.

20 MS. HUTCHINS: So there is actually insight for a
21 strategy there, which is to not label one particular program
22 or initiative "the" recovery initiative or "the" recovery
23 grant program, but to make sure that there is a much broader
24 emphasis and principal that pervades those things.

25 MR. GILBERY: Exactly.

1 DR. BRAUNSTEIN: And to give you an example just as
2 a followup, we assisted to peer run organizations to get one
3 of those grants. They have designed a peer run system of
4 services that we are administratively supporting, but the
5 grant is in their name. It is their program, they designed
6 it, and it runs very well. It is continuing to grow.

7 As a matter of fact, we now in our own intake
8 system offer people either or both options. They can come in
9 for the more professional level of treatment that we usually
10 do, or they can go over there or they can do both. In
11 essence it has worked very well. But that is an example of
12 how your grant is already actualized.

13 MS. HUTCHINGS: Fran, thank you for your patience.

14 MS. HARDING: That's okay. My comments were a
15 couple of comments ago, just agreeing and pointing out that
16 we have a system. Under Kathryn's vision, we have over 5,000
17 today, as much as I could count until now, of coalitions that
18 are in our communities creating a base of a sea change out
19 there, health and wellness.

20 So to build onto your vision, you said that you
21 have seen pockets of excellence. Well, those pockets of
22 excellence at the community coalition level are across the
23 country. If we maybe matched areas of the country with some
24 of the highest needs with some of the pockets of excellence,
25 which I'm sure there is an overlap there, it would take very

1 little money to redesign a focus of looking at this whole
2 idea of recovery oriented systems of care.

3 The only caution is, you don't want to make it look
4 like it is a new thing, or we are going to something
5 different, because too much change at one time, if we already
6 have the parents and community leaders and educators and all
7 the people that have something to do with the health and
8 wellness of a community working together to focus on
9 substance abuse and mental health.

10 So to make that leap into trying to put a cover on
11 it, it really isn't that far-fetched of an idea. Also, it
12 might help with sustainability. Of all coalition type
13 activities, sustainability is always a problem. It is
14 something that we spend a lot of time talking about. So if
15 they have a different kind of direction to take all their
16 energies, combine it with mental health and treatment, I
17 don't know, we might be a little bit closer because we will
18 have our public education marketing part done. It is a
19 matter of tweaking it.

20 So it is more of a support to the question that you
21 had, linking to some of the other comments.

22 DR. BRODERICK: In response to George's comment
23 about labels and how we communicate with our colleagues in
24 other sectors, and it touches also on George's comment about
25 branding, as we talk to people in the health system in

1 general who deal with chronic disease and describe mental
2 health and addiction disorders as chronic diseases, we can
3 talk about the management of those diseases. It would
4 require some sensitivity internally to not abandoning the
5 label of recovery, but medical providers understand the
6 management of chronic disease.

7 In the public health community they understand
8 tertiary prevention. We are talking about tertiary
9 preventive systems, in other words, what it takes to manage a
10 condition that already is impacting upon an individual's
11 life, whether it is diabetes or another chronic disease, and
12 what it takes to keep that from getting worse. That is in
13 fact how public health people refer to recovery support
14 services, for whatever condition they might be talking about
15 They are tertiary preventive activities.

16 So I think we can perhaps avoid the danger that
17 George and Wesley have talked about in terms of, recovery
18 support is this administration's deal. They are well used
19 and well worn terms in two other communities that offer that
20 translation that George was referring to.

21 MS. HUTCHINGS: There certainly seems to be for me
22 a recurring theme about -- I have heard it from you, and one
23 that I interviewed said, we have got to figure out how to
24 start speaking in dialogues that are more prevalent in other
25 systems and us adapting to that so that we can become part of

1 these conversations.

2 I would like to ask some of you, Ken, before you
3 were talking about influencing particular stakeholders and
4 speaking the dialogue. You have had a lot of hats, state
5 side, mental health and substance abuse, now county side. If
6 you had to prioritize three of those groups that should be
7 influenced in ways to carry this dialogue by creating a
8 sustained recovery oriented system, what three would you pick
9 as the most important?

10 MR. STARK: Small business community would probably
11 be my number one group, and I will give my rationale for
12 picking them as number one. They ere the predominant group,
13 both nationally as well as in Washington State that were
14 misinformed about the cost of adding mental health and
15 alcohol/drug treatment to private health care plans,
16 believing that it would devastate their expenses. So they
17 would be a primary group.

18 One of the ways to get involved with that primary
19 group is not only through your local small business various
20 associations, but also through your United Ways and your
21 chambers of commerce and your Kiwanis Clubs.

22 Another major group that clearly would be targeting
23 is the state legislature. You can do that both locally as
24 well as nationally through the National Conference of State
25 Legislatures. The other group that I would be working with

1 is clearly the health care community in general, which would
2 include not only the primary care folks at the hospital
3 association and oral health folks and public health agencies.
4 Some of those are already advocates, but they need to be at
5 the table with us as we move forward to try to look at any
6 policy change.

7 MS. HUTCHINGS: Others?

8 MR. STARK: The other thing to remember is, this
9 assumes of course we have got the families and consumers and
10 providers and our usual and customary group with us. These
11 are in addition to those.

12 MS. HUTCHINGS: And we know hopefully not to make
13 that presumption all the time, but to make sure that we are
14 reflecting it. Cynthia, groups that you would prioritize?

15 MS. WAINSCOTT: I think one of the great
16 opportunities looking ahead five to ten years is veterans'
17 health care. There is going to be a lot of attention to it.
18 I have been gratified to see that it has not waned at all.
19 In fact, it seems to be growing. I think to the degree that
20 we can pay some attention to that and help fully develop
21 recovery systems there, it will become a demonstration. I
22 think we are lacking in demonstration that is broadly seen,
23 and I think that is one place we could do it.

24 Another thing that I would urge us to do, and this
25 is not a specific group to work with, but it creates a new

1 group, you called them community leadership training,
2 Kathryn. How many of you have DD councils in your
3 communities? Do you know what they do? Have you watched
4 them be effective in the legislature in spades?

5 We don't have anything like that. To the degree
6 that we could do some kind of community leadership training
7 that would give us, both people that are connected to us and
8 who are effective in their communities, taking the message
9 forward. The way DD councils are, we could have a huge
10 impact five, six, seven, eight years out.

11 MS. HUTCHINGS: DD being -- ?

12 MS. WAINSCOTT: If anybody doesn't know what that
13 is, they are federally funded. They generally are housed in
14 the governor's office. They have employees. They kick butt.
15 That is what they do.

16 MS. POWER: I ran a DD council as a part of the
17 state system, and Cynthia is right on target.

18 MS. WAINSCOTT: And that doesn't matter, what
19 administration is in charge. That is something that you grow
20 and it becomes a force in the community. So those are my two
21 thoughts.

22 MS. HUTCHINGS: Terry, I can't tell if you are on
23 the fence.

24 MR. CROSS: I just wanted to add education. It
25 dovetails here. For us, the National Congress of American

1 Indians has put together a coalition of the National Indian
2 Health Board, National Council on Urban Indian Health,
3 National Indian Education Association and the National Indian
4 Child Welfare Association, into a Native Children's
5 Coalition, to jointly work on several policy issues. We are
6 finding it to be a very effective way to have the
7 conversation with our Congressional representatives on a
8 variety of issues.

9 Also, the broader child welfare advocacy community
10 that is surprisingly diverse itself is forming broader
11 coalitions across the whole range of issues. A really great
12 example of that was the Pew Commission on Child Welfare
13 Finance Reform, to come to some consensus about how to handle
14 those issues.

15 So those are two models of an increasing process of
16 groups coming together and having a stronger voice because of
17 that. So just to say that there are good models out there.
18 The funding communities, the federal agencies coming together
19 with the advocacy and the consumer groups.

20 MS. HUTCHINGS: So let's use that if we could to
21 segue into the home stretch here. This is about focusing on
22 partnerships and the models of partnerships you just
23 mentioned, and how would those help. What are your
24 suggestions for helping SAMHSA and our fields to focus on
25 creating the recovery oriented systems, sustain those

1 systems?

2 Here is another three points that you made in the
3 phone interviews. The question needs to be framed in the
4 context of competing interests in the federal, state and
5 community levels. Partly your construct, Kathryn, about
6 boundaries and understanding who those factors are, where
7 those power sources are. SAMHSA has a particular set of
8 interests that are in competition with other HHS agencies and
9 departments, thus sustainability becomes a priority setting
10 dilemma.

11 The direct quote is a political priority setting
12 dilemma, if I recall it, what do legislators and other key
13 stakeholders need in terms of information written in their
14 dialects, came up so much today, so they understand and will
15 advocate for this.

16 So to remind us about the framework, we started
17 with this conversation visioning, recommendations for a five
18 to ten year window, and now into practical recommendations
19 for action oriented partnerships, input for SAMHSA to
20 consider.

21 Is that close to what you were going to talk about,
22 Larry?

23 DR. LEHMANN: Coming off Cynthia's comment about
24 the issue of veterans' health care as a living laboratory to
25 demonstrate recovery in a broad national system is certainly

1 something that we are trying to do.

2 I think the point is that we are focusing not only
3 on the newer returning veterans, who are a major, major focus
4 of attention, very, very important for us, but also showing
5 how this is relevant for veterans of all service eras. That
6 intimately involves partnerships, because it involves
7 partnerships with in particular the veteran and the veteran
8 advocacy communities. They are the ones who are going to
9 have to carry this across.

10 This is a movement. We really have to identify the
11 people who believe in the movement. But the people who are
12 going to benefit from it are in fact the veterans, the
13 veterans' families and society in general. To show them what
14 it is, to be sure they understand what it is so they can
15 advocate and push for it, no matter who comes in at the city,
16 state or federal levels, is what we really have to do. That
17 involves all the things you talked about, like education and
18 things like that.

19 Certainly we are going to do that. I don't see VA
20 backing away from that. Quite frankly, I don't see the
21 consumer and consumer advocate communities backing away from
22 it. It has been articulated by the President in the Freedom
23 Commission. It has been articulated by SAMHSA. It doesn't
24 matter what you call the concept. People still call it
25 recovery because it makes sense, but whether you call it

1 wellness, showing that recovery and wellness are parts of the
2 same coin, I think it is going to continue to have that
3 strength.

4 I think we have to realize that, and work to do
5 that, particularly by having the partnerships with those non-
6 traditional entities such as for example the advocacy groups
7 that will carry that work for us outside of any of the
8 government levels.

9 MS. WAINSCOTT: This may be a little controversial
10 to say, but I worry when we talk about public safety and
11 mental health in the same issue, because of the way it is
12 often twisted.

13 I would propose that when you think about what kind
14 of information written in their dialects we need, that
15 instead of doing that, although there are some closed door
16 places you need to do that, but in our public communications
17 we talk more about the prevention of disability. We have
18 compelling data from -- what was the name of that report, the
19 World Health Organization -- can't remember the name of the
20 report now.

21 MS. HUTCHINGS: The local burden of disease.

22 MS. WAINSCOTT: The local burden of disease, thank
23 you, the top ten causes of disability, five are psychiatric
24 disorders. That is a compelling argument that everybody
25 hears. You can put the economic argument in that, you can

1 put the human argument in that. I have been quite frankly
2 gratified to hear how well that has been received at the
3 National Council on Disability. It is not something they
4 have been thinking about much, and they are thinking about it
5 a lot now, because it is a compelling argument for what we
6 should be doing. It doesn't have some of the stigmatizing
7 dangers, not because of what we are saying, but because of
8 how it is received sometimes when you talk about the public
9 safety issue.

10 MS. HUTCHINGS: Let's stay on this partnership
11 theme. Let's start with SAMHSA. Who are we not talking to,
12 we the fields, we SAMHSA, that we should be?

13 MR. STARK: What I haven't heard much today about
14 so far is, what about the early learning folks? The ECAP,
15 the state counterparts to Head Start. There is a lot of
16 focus on early learning right now around the country, more
17 research coming out. The policy makers have a little more
18 open passion when we are talking about young children than
19 maybe they would when we are talking about some of the other
20 populations.

21 A number of the parents of those children have
22 issues with mental health and alcohol/drugs, and a number of
23 those kids as they grow up may have issues around
24 alcohol/drugs or mental health. So I think it is one of the
25 groups that we want to partner with.

1 We talk about, the population is getting older.
2 What about the organizations that represent older adults?
3 They are a big group. You have got issues around
4 prescription drugs, you have got issues around depression,
5 you have got issues around alcoholism.

6 So I think there are a number of those groups. I
7 am not necessarily up on all the groups that SAMHSA is
8 partnering with, and I'm sure different parts of SAMHSA are
9 partnering with some of those groups already. But I haven't
10 seen much in terms of a national movement on that
11 collaboration coordination, like I have done with Medicaid or
12 with other disability groups or with criminal justice, where
13 it has been a much more visible collaboration.

14 Then also the workforce development councils and
15 whatnot as I said earlier. So we truly have to be able to
16 tie into the business community, and we have to be able to
17 tie into jobs and economic development, and talk about the
18 lack of our services become a barrier to economic
19 development.

20 DR. GARY: I wanted to add to Ken's list another
21 group. I solely agree with you about early childhood
22 education, et cetera, but I also wanted us to think about
23 faith based organizations. For some individuals and some
24 communities, faith based organizations are the first step
25 towards seeing health care, especially mental health care,

1 conflict and families related to alcoholism, substance abuse.
2 the whole issue of stigma and shame would take a person to
3 talk with their minister rather than to a health care
4 provider.

5 So I think that we need to figure out a way that we
6 can involve a variety of philosophical positions from faith
7 based communities, because they are very, very powerful.
8 They are especially powerful for individuals who are
9 marginalized, disenfranchised and have no insurance. That is
10 one group.

11 The other group that I think we need to give some
12 deliberate thought about is law enforcement. They are the
13 first responders. I have worked with them, and what they
14 tell me is that they are asked to do a job that they are not
15 prepared to do. They get little education about mental
16 illness, about substance abuse, about family conflict, about
17 how to go into a family and de-escalate some conflict or
18 whatever. So I think they would have a lot to bring to the
19 table also.

20 The other groups that I think we need to be more
21 attentive to is ethnic minority groups. We have tribal
22 councils, we have tribal colleges, we have the historically
23 black colleges and universities, who have very different
24 perspectives, very different kinds of mindsets about how
25 things should be, about training, about historical issues

1 that they could share with us, et cetera. Hispanic serving
2 colleges and universities would be another such group that I
3 think we need to give some attention to.

4 MS. HUTCHINGS: You have been sitting a long time.
5 How are you doing?

6 DR. GARY: Also I would like to add to that health
7 professionals in oral health, dentists. I just need to put
8 that in the record. We know that individuals with stand-
9 alone system and mental health problems have a lot of oral
10 health issues. So I think we need to make sure that we cover
11 the issue of oral health.

12 MR. STARK: I'm sure, Faye, that you included fire
13 and emergency medical with law enforcement as first
14 responders.

15 DR. GARY: Absolutely.

16 MS. HUTCHINGS: There is a little lull. Is that me
17 projecting?

18 MR. CROSS: I just would add that the area of
19 economic development, along with workforce development, is
20 important here. Part of the process of recovery is having a
21 job, but it also means having a job to go to. Some of
22 the ways that investment is being made in communities where
23 there are pockets of poverty.

24 This whole area of poverty is deeply intertwined
25 with mental health issues. I don't think we pay enough

1 attention to the linkage of the two. We have had a lot of
2 discussion around a lot of other issues today, but not too
3 much around poverty. If you look at the data, what the high
4 correlates are for some of the precursors to mental health
5 problems, poverty is right up there.

6 So I think linkages with the Department of
7 Commerce, for example, some opportunities to leverage some of
8 the economic development opportunities that are going on in
9 depressed communities to engage the recovery community.
10 There is as far as I know very little conversation going on
11 there.

12 Some of the work -- for example, there is a lot of
13 work going on in the philanthropic community with the
14 development of micro enterprises, the IDAs, the individual
15 development accounts, where people learn about savings and
16 developing of capital, the young entrepreneurship development
17 projects that are going on in tribal communities.

18 So there is a lot of ways to create not just self
19 help, but capacity building for people through a range of
20 activities that help people fulfill their lives and creating
21 economies where economies are depressed, creating capacity
22 for people to sustain themselves.

23 There is a colleague of mine in Minneapolis that
24 says there is not a lot of mental health problems in the
25 Indian community that a washer and a drier don't go a long

1 way towards fixing. So just making sure that we are thinking
2 holistically about what people do with their lives once
3 engaged in this process of recovery.

4 MS. HUTCHINGS: The Department of Commerce, Labor.

5 MS. KADE: I just wanted to point out from the
6 budget prevention that we still have budgets that are in
7 silos. When we talk about partnering, there is always this
8 reaction of the mission creep and the overlap and
9 duplication, which does not mean we should not partner, but
10 to have common goals doesn't necessarily mean the same roles.

11

12 I think we get into some challenges, especially
13 with recovery support services, because they look so similar
14 to the other services that our other federal partners
15 provide. Just a comment.

16 MS. WAINSCOTT: Marvin, your comments about having
17 identified people in your masters class who are going to go
18 out and hurt people are ringing in my ears, because I know
19 some of those folks who have gotten into the field.
20 Fortunately there are many, many people who have been trained
21 appropriately and understand it.

22 But I think if we are really going to have a
23 recovery oriented system, one of the things we have to do is
24 begin to talk in a different way to the universities that are
25 training these people. I am talking about not only training

1 them as health professionals, I am talking about training
2 teachers, policemen, MDs.

3 My daughter took a masters in education recently,
4 and I asked her to clock the number of hours she was talked
5 to about mental health. She said it was two hours and 15
6 minutes. That needs to change. That is free. We don't have
7 to spend money to have those discussions.

8 I propose that when those discussions are held with
9 people with the illnesses and their family members be part of
10 the discussions, with the people who are going to be making
11 the decisions about whether to make changes or not, because
12 they make very different arguments than people who are
13 professionals.

14 DR. WANG: It is probably getting late. I can't
15 keep thinking about what I am supposed to think and say and
16 so forth.

17 I just want to react to your question about
18 partnership. To me partnership is about relationships. I
19 think maybe that is more strategic rather than saying which
20 are the partners and so forth. I don't know in terms of what
21 relationships have SAMHSA done for the past number of years.

22 My experience about relationship building and
23 trying to achieve some partnership is that I always use that
24 concept of an airport hub. Someone mentioned about
25 Minneapolis. That is why I free associated with that; I said

1 Northwest Airline. You have a lot of airlines fly into
2 Minneapolis, and Northwest Airline is the hub plus the other
3 companies and so forth. In order for everyone to come into a
4 hub or to an airport everyone has to share similar needs and
5 messages and so forth.

6 Part of it, I have to go back into the earlier part
7 of the last question when I said that recovery is the process
8 and wellness and well-being is the outcome. I think in some
9 sense in other to have partnership you have to have a clear
10 message. You have to have a clear something for people to
11 discuss.

12 One of the lessons learned that I have currently
13 going through in Massachusetts is trying to build this hub,
14 where everyone can come in and share the same message. That
15 is difficult, because everyone comes in with their own
16 interests and advocacy and so forth, so there will be a lot
17 of give and take given with that message, in terms of how do
18 we create this groundswell of support in terms of creating
19 and sustaining the recovery oriented system.

20 I have to emphasize again, the lesson learned is
21 who have you established the relationships. Those
22 relationship is really about trust, so that people do not get
23 defensive and say this is a competing agenda with my agency,
24 but rather say that we have a common effort here. If we have
25 some consensus in regard to the definition, in regard to

1 wellness, in regard to recovery, then I think that will be an
2 easier way to form that partnership, and it is easier to have
3 some support. They don't have to agree with us in everything
4 because of what they are responsible for and so forth.

5 MR. BRAUNSTEIN: Ed said part of what I was going
6 to say. I do believe that it is not who else needs to be
7 contacted as much as -- not that I disagree with any of the
8 referenced places, but it is the message. I think the
9 message can be more specific now that there is more specific
10 information, and the people listening will understand it.

11 The only other comment I would make is to what
12 Daryl said, which is that to the extent that it is possible,
13 I think it is important that if your message out to the field
14 is, get your act together and it goes the same way, that the
15 messages coming out of SAMHSA have to be consistent from all
16 parts. One can speak for all when it comes to key concepts,
17 even if the budgets are silo'd. If Kathryn is speaking about
18 recovery, she is speaking about it for both mental health and
19 substance abuse, for example.

20 I assume that can happen, because that message has
21 to be consistent and clear and can't be parsed in different
22 terms. We are trying to move away from even the silo of
23 different disabilities to the extent that we can. We can't
24 control our budgets necessarily all the time, but we can
25 control our organizational philosophies.

1 MS. HUTCHINGS: Any other ending comments?

2 Excellent, another excellent afternoon of conversation.

3 I believe the plan is to give people a break until
4 four o'clock, and then you will reconvene at four. In terms
5 of the two topics we have spoken of today, we will have an
6 hour together tomorrow morning to see if anything as occurred
7 to you overnight tonight. I'm sure this is all you will
8 think of and focus on until then. So we will come back
9 together for an hour in the morning, and then adjourn fairly
10 early for the recovery walk, too.

11 So I really appreciate very dynamic and focused
12 participation by all of you. Thank you very much.

13 (Brief recess.)

14 **Agenda Item: Update on Legislative Issues**

15 DR. BRODERICK: -- Michelle Dirst. But before I
16 call on Michelle, Ed, did you want to say something to the
17 Council?

18 DR. WANG: Yes. I just wanted to say to the
19 members of the Council and also to Dr. Broderick that I have
20 to leave tonight, return back to Boston because of a meeting
21 tomorrow. So my apology to the Council members as well as
22 Dr. Broderick, not able to participate for the tomorrow
23 session.

24 DR. BRODERICK: Thank you, Ed. Michelle, the floor
25 is yours.

1 MS. DIRST: Thank you. I am very happy to be here
2 today. My name is Michelle Dirst, and I work as a
3 legislative analyst for the agency. Basically that is
4 working with Congress, the liaison between Congress and the
5 agency.

6 To be honest with you, I sat down to start
7 preparing this presentation, and I gave myself about an hour
8 and a half, and it took about 30 seconds, when I started
9 thinking about what Congress is doing.

10 I want to talk to you a little bit about
11 reauthorization, appropriates and mental health parity. I
12 think that is what is of most interest to you all. The last
13 time you were here, Joe Faye, who was our legislative
14 director, gave you an update about reauthorization. At that
15 point we were still kind of in the middle, thinking that it
16 was going to go, about a 90 percent chance. That ten percent
17 chance came through.

18 I have to tell you, the Center was the one that
19 took the lead on reauthorization. They really did a nice job
20 of doing bipartisan reauthorization. Senator Kennedy, who is
21 the chairman and ranking member, had about 13 staff from both
22 sides of the aisle at every meeting, and they really tried to
23 compromise, to come together on this bill. They were able to
24 achieve that.

25 It was supposed to be marked up last December.

1 They had a date. In the last meeting before markup this
2 issue was raised about charitable choice, and we call that
3 now the atomic bomb. I see some people are shaking their
4 heads; they have heard of this. During the 2000
5 reauthorization there was a provision that was included about
6 the charitable choice. It allowed faith based organizations
7 to apply for grants and hire people of their same faith.

8 There is a question of, is that discrimination, for
9 federal funds to go to entities that can hire their same
10 faith. That is really the issue with charitable choice. On
11 any other issue there could have been a compromise, but this
12 was pretty much black and white. The Democrats wanted to
13 pull it, the Republicans wanted to keep it in. It stalled
14 the bill, and that pretty much killed it. We haven't heard
15 much about it since then.

16 I doubt any provisions relating to SAMHSA will pass
17 in the next three weeks. Congress came back into session
18 today, and they will be in for about there or four weeks, and
19 they will go out until after the election. They might come
20 back for a lame duck, that is not really clear. The next
21 three or four weeks they have a lot of the agenda with the
22 takeover of Fannie Mae and Freddy Mac. They also have to
23 pass the continuing resolution to make sure that -- and that
24 means that all of our programs will be funded at last year's
25 level.

1 It is not clear -- and this is kind of standard --
2 if Congress doesn't pass an appropriations bill. An
3 appropriations bill is what funds the agency. It may be
4 required. All the programs have not been reauthorized. That
5 means they expired in 2003. As long as we get money for our
6 programs we will continue.

7 The Senate did pass an appropriations bill and
8 funded SAMHSA at about \$3.3 billion. The House was not able
9 to -- oh, they marked up a bill, then it passed the Senate.
10 The House wasn't able to mark up a bill, but unofficially
11 they would have funded SAMHSA at about \$3.4 billion. In
12 fiscal year '08 we were funded at \$3.3. So both of them
13 would have given SAMHSA a boost. So we will have to wait and
14 see until after the election if there will actually be a bill
15 or not. There is some thought that if Obama becomes
16 President there will be an appropriations bill, and to fund
17 any sort of appropriations that has earmarks. So there could
18 be FI, which means it will continue to be in a continuing
19 resolution until some agreement is reached between McCain and
20 Congress.

21 So right now with reauthorization we are in a
22 standstill. Nothing is going to happen. Appropriations, we
23 are waiting until the next President comes in to see what is
24 going to happen.

25 If you have any questions on either of those two

1 issues? You need clarity between reauthorization and
2 appropriations. They are two separate processes.
3 Reauthorization is what tells us what we can do,
4 appropriations process is what gives us the money.

5 I will move on to mental health parity. There is a
6 little more optimism with mental health parity. Yes, sir?

7 MR. CROSS: I had a question about reauthorization.
8 It looks like we are going to roll into the next
9 administration with reauthorization regardless of what is
10 going on right now.

11 My question is about process and opportunities that
12 might arise for rethinking what is in the current bill. What
13 is your thinking about strategy for the next Congress?

14 MS. DIRST: A lot of that even for us, it depends
15 on one, the Congress, if the Chairman wants to try and take
16 up SAMHSA reauthorization again, and then it depends on the
17 new administration, to see where they would like to take the
18 agency, whoever will again have to be appointed Administrator
19 and if he has any ideas. So I think at this point it is
20 difficult to say.

21 The one good thing we did during this
22 reauthorization, we didn't have any huge changes that we
23 needed, but we welcome that dialogue that Congress has about
24 the mental health and substance abuse programs. For them it
25 is also an education process, to let them understand our

1 issues better.

2 But I think the main issues that we had last time
3 was that I could see carrying over would be with the block
4 grant. There is an effort to have a state plan. I believe
5 mental health currently has one, but there was an effort to
6 include a state plan for substance abuse, and I can see that
7 continuing.

8 MR. CROSS: One of the reasons I asked that
9 question is, the transition through whatever the next
10 administration is, that the advocacy community and the work
11 that was done between SAMHSA and advocacy groups, including
12 the National Congress of American Indians, to get to where
13 the draft was when it got ready for markup, is going to be a
14 very important dialogue. It is important to continue in the
15 coming months so that we don't lose ground and perhaps can
16 even gain ground for some of the things that we have talked
17 about on this Council. It seems like this is a time of
18 opportunity.

19 So not just taking a wait and see attitude, but a
20 let's talk and prepare attitude for the next Congress.
21 That's all.

22 MS. DIRST: I think that is always good. In my
23 past life I worked for a Senator. What is always helpful is
24 for the groups to get in there and talk about their priority.
25 I know you guys aren't allowed to lobby, there is some

1 ethical situations, but in your advocacy portfolio, as long
2 as you split your activities.

3 Any other questions?

4 Mental health parity. There has been an agreement
5 reached between -- the Senate had one mental health parity
6 and the House had another mental health parity bill. They
7 both passed a bill, and a compromise has been reached between
8 the two. The difficulty now is finding a three billion
9 offset. During August there was an effort to include the
10 bill. I believe it was a tax bill, and some issue came up
11 about energy that held up the bill, and it didn't move
12 through. So they are going to try again during September.

13 DR. HUMPHREYS: Can I interrupt for just a second
14 and ask you, I have heard this and I haven't understood it.
15 Three billion for what, to pay for what?

16 MS. DIRST: It is predicted that it will cost three
17 billion to carry it out, and I'm not sure the extent of time.
18 So it is the offset.

19 MS. POWER: It is the Congressional Budget Office
20 estimates for instituting parity. That is what they came up
21 with.

22 DR. HUMPHREYS: This would be the cost of
23 monitoring the regulation?

24 MS. DIRST: Including the provisions. There are
25 two ways to think about it. An insurance company is to

1 include -- if they currently have mental health as part of
2 their portfolio and they have to provide parity, if during
3 the first year it goes above two percent, then they could be
4 exempt, and then following years that is one percent. So
5 that would be the cost to providers and the insurance
6 company. Also, for implementation there is still going to be
7 a cost to the federal government.

8 So that is what they are looking for at this point.

9 Fingers are crossed. They are kind of up against time.

10 Domenici, who is the Republican sponsor on the Senate side,
11 he is stepping down at the end of the Congress, and Ramstead,
12 who is the Republican House sponsor, he is also stepping
13 down. We all know Senator Kennedy's situation. He is
14 supposed to come back in January, but -- so the hope is they
15 do get pushed through this year. I know the advocacy groups
16 have a call-in day on September 10 to try to get their
17 delegates to move it through. So there is some optimism that
18 that will go through.

19 Yes, sir.

20 MR. STARK: No offense to any consultants in the
21 room, but probably half of that cost is going to go to
22 consultants doing training and various kinds of consulting
23 work and that sort of thing. That is the way it usually
24 comes down.

25 MS. DIRST: Thank you for that.

1 DR. HUMPHREYS: So could you tell us which standard
2 prevailed? Is it that parity applies if you choose to offer
3 mental health? Or is it that you have to offer mental
4 health?

5 MS. DIRST: It is for those group plans that are
6 currently offering mental health. It has to be equal to
7 behavioral health. Right now it is just for annual limits
8 and lifetime limits. This would include -- I have a cheat
9 sheet. This would include all financial requirements,
10 deductibles, copayment, co-interns and out of pocket
11 expenses, and also for treatment limitations, day and visit
12 limitations.

13 DR. HUMPHREYS: So there is nothing in the law that
14 would stop a business from saying, we are just not offering
15 any mental health insurance at all?

16 MS. DIRST: That is --

17 DR. HUMPHREYS: That is what I thought.

18 MS. DIRST: Yes.

19 DR. HUMPHREYS: Thank you.

20 MS. DIRST: Yes, that is one of the concerns that
21 have been brought up. If there is a state that offers beyond
22 the federal law, at one point during the Senate it was the
23 floor and ceiling, and right now if those states offer beyond
24 the federal, then they can continue to offer beyond.

25 That is about all I have. Do you have any other

1 questions?

2 DR. BRODERICK: Thank you. At this point in time we will
3 offer an opportunity for public comments. We have there
4 public comments. Dr. Madrid?

5 **Agenda Item: Public Agenda**

6 MR. MADRID: Dr. Broderick, Council members, I want
7 to thank you for the opportunity to present to you today. I
8 am going to give you a three-minute mini-report on something
9 you should definitely know, and this why the US drug
10 treatment gap is increasing and dramatically changing due to
11 the recent Mexican drug cartel violence along the US-Mexico
12 border, and what I think we can do about this.

13 In the last six months, along the US-Mexico border,
14 there have been 900 people who have been assassinated by drug
15 cartels as they compete for the drug trade in supplying the
16 20 million consumers on the US side. Many of the
17 assassinations are being carried out, according to FBI
18 sources and DEA, by youth gangs that are American.

19 The other thing that is happening is that this
20 cartel activity is driving drug prices to an all-time low,
21 making these hard drugs affordable for college, high school
22 and middle school students according to again the media and
23 some of our criminal justice authorities. According to the
24 FBI sources these cartels have established 36 cells in 36
25 different major cities in this country, to include Portland,

1 Sacramento, Atlanta, Boston, Columbus, Chicago and thirty
2 other major cities in Texas. And the way the cartels are
3 looking at this situation is that there are 20 million people
4 in this country that are not going through treatment. You
5 look at fifty dollars each a day for consumption of drugs --
6 that is a \$1 billion a day business. So they are killing
7 each other off trying to compete for this business. IF you
8 look at a hundred dollars a day consumption, we are talking
9 about a \$2 billion a day type of business that they are doing
10 on the American side.

11 SO that is why there is so much competition.
12 According to the FBI and media sources, these cartels are
13 flooding the US cities with cocaine, heroin and a new, more
14 potent methamphetamine, again targeting the 20 million
15 consumers. They are going after the high schoolers, the
16 college students, the middle schoolers. There are media
17 releases where there are a lot of high school students who
18 have been arrested who have been prosecuted because of their
19 drug dealing. I am talking about 16- 17-year-old boys
20 trafficking a ton of cocaine a week.

21 Several months ago the US Congress enacted a
22 congressional bill that appropriated approximately \$1.8
23 billion that is going to go to Mexico to try to deal with the
24 supply side type of problem and develop supply reduction
25 measures. Our drug treatment program, the one that I

1 represent along the US-Mexico border, being one of the most
2 comprehensive, was asked for input. My input consisted of
3 this -- if you are going to spend \$1.8 million in doing
4 supply reduction, then why not spend \$1.8 billion doing
5 demand reduction?

6 At this time we are still advocating for that
7 particular position. We are continuing to work very
8 aggressively with Senator Kay Bailey Hutchison and
9 Congressman Silvestre Reyes, who was the Chairperson of the
10 House Select Committee on Intelligence, in trying to develop
11 some parity, some equitability concerning supply side and the
12 demand side.

13 Today as I close, I am here to plant the seed about
14 what is happening in the substance abuse arena at the grass
15 roots, the Congressional level, as well as the international
16 level, that I believe might very well transform the field
17 throughout our country.

18 You as distinguished Council members and national
19 leaders, you need to know and perhaps even get involved on a
20 personal level, since you all can advocate or lobby as a
21 group to get involved. The transformation is inevitable.
22 There are 20 million people that are not in treatment. These
23 cartels are going to supply them, and it is going to
24 transform the way we do business as treatment providers, as
25 prevention specialists and so forth. These cartels will go to

1 every extreme.

2 I went ahead and mailed to Ms. Vaughn some of the
3 media releases that you all might want to look at. Thank you
4 all very much. Again, I appreciate the opportunity.

5 DR. BRODERICK: Thank you, Sir. The next comment
6 is from Andrew Kessler.

7 MR. KESSLER: Good afternoon. Thanks for this
8 opportunity. Three minutes to sum up about a year's worth of
9 work for the group called the Friends of SAMHSA.

10 The Friends of SAMHSA is a fairly new organization.
11 We are not even a year old yet. We are a coalition of
12 organizations and individuals dedicated to not only advancing
13 SAMHSA's prominence in the health care debate, but also in
14 establishing a dialogue, so that SAMHSA and the people all
15 across the country who work with consumers can improve their
16 communication for the betterment of all involved.

17 We have about 15 groups that are right now members
18 of the Friends of SAMHSA. Just an example of who our members
19 are, the Suicide Prevention Action Network, the California
20 Network for Mental Health Clients, Entertainment Industry
21 Council, the International Certification and Reciprocity
22 Consortium. So that is just an idea of who we are bringing
23 to the table to hopefully bring into the fold.

24 We have been sitting here for about six or seven
25 hours, talking about where SAMHSA has been, where SAMHSA is

1 going and who our partners should be. We are your partners,
2 for starters. Friends of SAMHSA is doing a lot to spread the
3 word of the good work that SAMHSA is doing across the country
4 so that people are more aware of where their help is coming
5 from.

6 Right now, the consumers and even the people who
7 work as beneficiaries of SAMHSA's funding and their block
8 grants aren't really aware of the good work that SAMHSA is
9 doing in places that they are not familiar with.

10 Right now, we also want to be visible on the Hill.
11 As Michelle said, not much is going on, but when Congress
12 comes back in full force in January we want to be up there
13 talking about appropriations, about reauthorization, and more
14 importantly about SAMHSA's place in the overall health care
15 debate.

16 There is going to be major health care reform in
17 the next few years, and SAMHSA has to be a part of it. There
18 is a saying in Washington: If you don't have a seat at the
19 table you are probably on the menu, so we want SAMHSA at the
20 table.

21 www.friendsofsamhsa.org. It is easy to remember.
22 friendsofsamhsa.org.

23 Some of the other work we have been doing recently.
24 We have been working with Recovery Month partners to
25 establish a survey in order to improve Recovery Month events

1 around the country, find out what is working and what is not.
2 We have been written up in Alcohol and Drug Abuse Weekly.
3 We are partners in the Whole Health campaign, which is
4 working to make mental health and drug abuse issues more
5 visible in the Presidential campaign. We have got a lot on
6 our plate. There are a lot of people out there and a lot of
7 groups and a lot of associations and a lot of other entities
8 that should be friends of SAMHSA that don't know it yet. We
9 would like to get the word to them as well.

10 I will be available to speak with you after we
11 adjourn today. Thank you for your time.

12 DR. BRODERICK: Thank you for the comment. The
13 last public comment from Brian Altman.

14 MR. ALTMAN: Thank you. If you don't mind, I think
15 I might be able to clarify the mental health parity cost. In
16 defense of one of my board members who is sitting behind me
17 who is a consultant, might help.

18 The three billion dollars is because, as many of
19 you know, when you pay for your employer based health
20 insurance, the amount you pay for the health insurance comes
21 out pre-tax. So when the Congressional Budget Office
22 estimates that, the cost of your premium will go up .1
23 percent, based on mental health parity. That .1 percent
24 increase in cost of premium is what makes up the three
25 billion dollars in lost tax revenue.

1 It took me two years working on mental health
2 parity to learn that, but in my third year I got it.

3 Anyway, my name is Brian Altman. I am here
4 representing the Suicide Prevention Action Network USA as the
5 acting chief operating officer and Director of Public Policy
6 and Program Development. For those of you who are not
7 familiar with SPAN USA, we are a 501.c3 organization
8 dedicated to preventing suicide through public education and
9 awareness, community action and federal, state and local
10 grass roots advocacy. We are the only suicide prevention
11 organization that leverages grass roots support from
12 survivors of suicide, those who have lost loved ones to
13 suicide, and others to help change public policy.

14 In particular I wanted to talk about some of the
15 things that have happened since I last spoke to you last
16 September. In particular we want to thank SAMHSA for its
17 ongoing support, as well as for the full implementation of
18 the SAMHSA-VA hot line initiative. It was talked about a
19 little bit before, but basically I wanted to throw out some
20 of the stats that came out at the one year mark.

21 There have been 55,000 calls just in the first year
22 of operation of the press 1-800-273-TALK; 22,000 of those are
23 self identified veterans. I know most of the data says they
24 are veterans, but someone pointed out that it is self
25 identified veterans. That gap of 55 to 22 can actually be

1 many more veterans that have called the number and not self
2 identified as such.

3 Of course, one of the most important stats that we
4 learned at the one year mark was that there have been over
5 1,200 rescues. So literally somebody at the VA center
6 identified the person on the line as in such dire crisis that
7 it necessitated an immediate rescue. So when we fill out the
8 numbers, like 1.4 million attempts of suicide every year, we
9 know that at least 1200 of those attempts that have not
10 become completions are these rescues because of the VA-SAMHSA
11 life line. So we are certainly thankful to SAMHSA and the VA
12 for working together. We think it is an absolute model for
13 interagency cooperation.

14 Also, SPAN USA is looking forward to on October 1
15 actualizing the CMHS SAMHSA funded suicide prevention
16 resource center, SPAN USA National Action Alliance for
17 suicide prevention. Some of you may have heard about the
18 Action Alliance in previous meetings. It has taken a bit of
19 time to get going, but now in our concerted effort to work
20 with SAMHSA and SPOC, we are looking forward to finally
21 actualizing it. We thank SAMHSA for their ongoing effort to
22 insure that it does get going.

23 Finally, for your support of the Garrett Lee Smith
24 Memorial Act grantees. Within the last month, SAMHSA
25 announced its 11 new tribal grantees plus one tribal grantee

1 renewal, and we are looking forward to the announcements on
2 the FY '08 state grantees as well as the college and
3 university ones.

4 And of course, we want to thank the SAMHSA staff.
5 Acting Administrator Broderick, I was heartened to hear you
6 list suicide prevention as the first key area you talked
7 about this morning, as well as former Administrator of SAMHSA
8 Terry Cline's efforts, and our ongoing work with Mark Weber
9 and Richard McKeehan.

10 Finally, I just wanted to mention that we always
11 appreciate SAMHSA holding this National Advisory Council
12 meeting during this week. It is National Suicide Prevention
13 Week, so we certainly appreciate your attention to the issues
14 of mental health and substance use during National Suicide
15 Prevention Week.

16 So thank you very much for all of your efforts.

17 DR. BRODERICK: Thank you for the comment. That
18 concludes our public comments. We are just about to adjourn.

19 A couple of housekeeping issues. Not only is it
20 Suicide Prevention Week, it is also Recovery Month. It is
21 most fitting, I think, that given our conversation this
22 afternoon about recovery and recovery oriented systems of
23 care, that tomorrow we have an opportunity as a Council to
24 interact with SAMHSA staff during the Recovery Walk. It
25 starts at 10:30, so we will start at 8:30 instead of nine to

1 allow us to finish our business.

2 Those of you who are interested in walking, please
3 take the opportunity. It is a lot of fun. It is three
4 miles. You can walk all of it, you can walk part of it. It
5 is a great opportunity to meet the people who work here.
6 They will be strung out for a mile, and you can just mingle
7 among the group and talk to people you might otherwise never
8 have a chance to meet and talk to.

9 If you are interested in participating but don't
10 want to do the walk, there are roles to play for others in
11 terms of giving out water, lots of things. So I welcome you
12 to participate and encourage you to do so. If you are
13 interested, I think you will find it a good way to celebrate
14 recovery as a Council.

15 So with that, I would like to adjourn the session
16 this afternoon. We will convene as I said tomorrow again at
17 8:30. Thank you for the robust conversation this afternoon
18 and this morning, and I look forward to seeing you tomorrow.
19 Have a wonderful evening.

20 Thank you.

21 (Whereupon, the meeting recessed at 4:30 p.m., to
22 reconvene Tuesday, September 9, 2008 at 8:30 a.m.)