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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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1 P R O C E E D I N G S (8:30 a.m.)

2 MS. VAUGHN: Good morning, everyone. As the
3 designated federal official of the SAMHSA National Advisory
4 Council, I would like to call the meeting to order. Dr.
5 Broderick, we have a quorum. I will now turn the meeting
6 over to you.

7 **Agenda Item: Welcome, Opening Remarks**

8 DR. BRODERICK: Thank you, Toian. I trust you all
9 had a restful evening. Thank you for coming back on time
10 this morning.

11 What we will do today is a meeting that will last
12 until just shortly after ten o'clock. Gail is going to walk
13 us through the outcomes of yesterday's conversation. We will
14 have a presentation by Kevin Hennessy, and I think that will
15 wrap us up. So if you will bear with us for a couple more
16 hours, we will then be ready -- as long as the rain holds
17 off, we will be ready to do the Recovery Walk.

18 So with that, Gail, are you set?

19 **Agenda Item: Council Roundtable Discussion**

20 MS. HUTCHINGS: Good morning. How was your night?
21 This is not necessarily a summary, and it is not prettied up
22 yet. You had a lot to say yesterday, which was fabulous.

23 If you could please take a look to especially the
24 first couple of pages, what you see there is -- and thank you
25 very much to Irene yesterday for taking such copious notes.

1 Last night I cozied up to the computer and I went
2 through and tried to identify in the bold ink what I thought
3 was the key point of each one of your remarks from yesterday,
4 organized within the three areas we talked about for each of
5 the two topics. Does that make sense?

6 What I thought we would do this morning is ask for
7 your assistance in helping identify what some of those key
8 themes were that emerged from yesterday's conversation. I
9 also want to make sure that we keep time for any other new
10 thoughts that might have occurred to you overnight last
11 night, when I know this was the only thing you were focusing
12 on. Does that sound like a plan?

13 So we will take these in two chunks. The first one
14 about elevating the role of mental health and substance use
15 addictions, prevention and treatment in overall health. As
16 you have a minute to look through those, what were your key
17 thoughts? We can either go round robin or I can give you
18 another minute to take a look. Things that you see as key
19 themes that emerged from that vision part of the conversation
20 yesterday morning.

21 MR. BRAUNSTEIN: I think if I was to take a key
22 strategic directional theme that came out of the discussion
23 yesterday, going even further into the mainstream of health
24 care with mental illness and substance use disorders was by
25 far the biggest theme. I am avoiding saying become more

1 public health oriented, because I think once that moves along
2 down the stream, you may need to make adjustments based on
3 where the money is, where the system is going. It may not be
4 public health, but the key theme is to make sure that even
5 more and more, the disorders that we respond to in our system
6 are considered health problems of equal weight to any other
7 type of health problems such as diabetes, hypertension and
8 heart disease.

9 MS. HUTCHINGS: Good.

10 DR. BRODERICK: A couple of things for me. It was
11 the notion of integration across systems and the need to
12 create a sense of urgency and the need to be contributory as
13 opposed to demanding of the larger system.

14 MS. WAINSCOTT: I think one of the key things that
15 stuck with me was the need to critically figure out who the
16 right partners are and to get our language matching our
17 message, which I don't think it does now.

18 MS. HUTCHINGS: So I am hearing, elevating the role
19 requires elevating the role so it has some equality and
20 urgency, significance, et cetera, and partnerships.

21 MS. WAINSCOTT: I guess the other thing that was a
22 recurring theme throughout the day yesterday for me in both
23 discussions really was the role of the families and consumers
24 as the elevated voice.

25 What we didn't talk about, which occurred to me

1 overnight is, that increases our constituency to 100 percent
2 of the American population, if we take advantage of that. We
3 tend to think of our constituency now as the people who have
4 quote severe mental illness, serious mental illness and their
5 families. If we are going to do it -- I am going to talk
6 some about the public health model, because I think that is
7 where we have to go. I don't know that we use that language,
8 but we have got to talk about a continuum of care, we have
9 got to talk about population-based stuff. If we do that, our
10 constituency is 100 percent of the American population, and
11 that would be a huge shift in how we think and how we
12 communicate.

13 MS. HUTCHINGS: Your point in part reminds me of
14 Daryl's comment yesterday, about the role of SAMHSA to not
15 only count the people in need of services and receiving
16 treatment, but all the people in recovery as well, to help
17 make the case for that whole continuum, and for the
18 significant number of population that is affected, too.

19 MS. WAINSCOTT: The classrooms that don't function
20 as they should when the children that are not well, and for
21 the business places who are not as productive as they could
22 be because the people are not well, et cetera.

23 DR. DELANEY: I think coming up with the issue of
24 documenting the impact, instead of what we can just document,
25 this is the number of people and that is important, but also

1 the cost of this on other chronic illnesses. Related to
2 that, the financing and some incentives. So it is part of
3 that. Finding the right partners and talking to them in
4 their language also means saying if you don't treat this, you
5 are not going to improve the situation for your patients.

6 MS. HUTCHINGS: That was a big theme yesterday,
7 wasn't it?

8 DR. DELANEY: And the financing has to follow. If
9 we can move that into the mainstream discussion, the
10 financing, at the same time I think we also need to find ways
11 to move the financing back. I like the term upstream, so
12 that we are actually intervening before it becomes a problem,
13 not just with the unmet treatment gap, but with people before
14 they get to the point where you need to think about
15 treatment.

16 MS. HUTCHINGS: And of course I thought you made
17 another stellar point yesterday about needing to define what
18 some of that data was that we want to capture at the front
19 end, and including those conversations at the beginning. I
20 thought that was great.

21 MR. STARK: For me the issue was about the
22 partnering and the messages that we want to provide to those
23 partners, which includes the whole idea of data and being
24 able to tell a story when we have a partner about what is the
25 impact of not doing anything relative to alcohol/drugs and

1 mental health, and what is the value of doing something to
2 your group, whichever that group is that we are talking to.
3 Which means we are going to have to have multiple messages
4 and stories to tell.

5 It ties in even with a comment or two that was
6 written down from yesterday very specifically about creating
7 a story, an orientation for new Medicaid directors, a story
8 for new legislators that could be funneled through NCSL or
9 whatever, a story for new governors that could be messaged
10 through NGA. But that kind of thing, a story for new CEOs of
11 the United Way that could be messaged through that group.

12 MR. WEBER: One of the themes too that I kept
13 hearing yesterday is the concept of hope. I think it wasn't
14 said this way yesterday, but it is a matter of packaging and
15 selling solutions and hope.

16 I think when individuals realize, if there is a
17 cure and I know about it, I am going to do everything
18 possible to figure out how to get there, and people will
19 rally around to help achieve that. So by selling hope, there
20 are treatments, things will get better. We know that, so it
21 is like rallying around the individuals.

22 So bottom line, hope and selling solutions, the
23 package.

24 MR. CROSS: I think another theme particularly in
25 the context of SAMHSA is leadership and its power to convene

1 thought leaders.

2 MS. HUTCHINGS: Grant makers and other people
3 coming in with a strategic approach with SAMHSA, how you do
4 that.

5 DR. GARY: I think our discussion yesterday was
6 quite stellar. I think what resonates with me is the whole
7 sense of urgency as related to the essential component that
8 mental health plays in peoples' lives. I think in order to
9 broaden the stakeholders, which I think is a very important
10 concept, we need as many stakeholders as we possibly can,
11 people who provide physical health care. We need policy
12 makers, we need consumer groups, we need foundations, unions,
13 churches and whatever.

14 So I think we need to broaden our stakeholders and
15 make it very clear, using the sense of urgency, that without
16 mental health there is no health. If we adhere to the
17 upstream model, then we have to also address the social
18 determinants of health. So I want that to be a part of our
19 thinking, too, because you spend ten minutes in the doctor's
20 office, and we have all of these other social determinants of
21 health that influence and impinge on peoples' lives that we
22 have to be cognizant of, and make some plans to address in
23 the public health model.

24 MS. HUTCHINGS: Let's go back to your point about
25 creating that sense of urgency. Who is the we that is

1 responsible for that?

2 DR. GARY: I think the we that is responsible for
3 that is SAMHSA and every stakeholder that we can get to buy
4 into our plan.

5 MS. HUTCHINGS: Including this group?

6 DR. GARY: Including this group.

7 MS. HUTCHINGS: One of the pieces of constructive
8 feedback that I got from yesterday is, a person reminded me
9 that it was a great conversation, lots of good ideas, but it
10 was too safe. Most of the conversation was too safe. What
11 do you think about that?

12 MS. KADE: I thought the tax credits were not safe.

13 MS. HUTCHINGS: I knew that got your attention,
14 Daryl.

15 MS. WAINSCOTT: I think I would agree with that. I
16 think that is a product of how we have operated for a long,
17 long time. We have in many ways been put in a box. I am
18 talking now about the treatment system. The people that need
19 that treatment have been put in a box, and we need to break
20 out of it. That is radical change, and it is scary to think
21 about. People who operate the box think too much change
22 would be -- but we have got a crisis. The truth is, we have
23 a crisis. If SAMHSA can simply articulate that, and the idea
24 of articulating it to the right people is really important.

25 In other words, if you are talking to an emergency

1 room doc, their crisis is, they are overwhelmed. If you are
2 talking to sheriffs in South Georgia, they are angry at the
3 people that are in their jails. If you are talking to
4 teachers, they understand that the children that are there
5 that are failing, many of them are failing because they are
6 sick and nobody is taking care of them.

7 People are dying 25 years younger than everybody
8 else is. How is that for a crisis? Yet most people don't
9 know that. We haven't articulated it.

10 MS. HUTCHINGS: Is part of your point, Cynthia,
11 that maybe we have set our own expectations too low?

12 MS. WAINSCOTT: Yes.

13 MS. HUTCHINGS: And that we need to encourage
14 ourselves to bump it up?

15 MS. WAINSCOTT: There is a natural human tendency
16 to be afraid of change. What we are thinking and talking
17 about is radical change. When you talk about trying to
18 become part of a continuum of health care, that is very
19 different to what we have been doing for over 100 years. So
20 there is a lot of oxes to be gored in that, and it is going
21 to take some real radical thinking and pushing and un-safety.

22

23 MS. CUSHING: Yesterday we dipped our toe into the
24 idea of cost effectiveness. Certainly I don't think we
25 dipped our toe deep enough into the absolute cost

1 effectiveness of prevention in our upfront work. That
2 conversation probably needs to be a little more robust, to
3 take some responsibility for that.

4 However, if we don't look at what we as
5 professionals in the field and the stakeholders that Faye is
6 talking about and the elected officials, and particularly
7 those medical and health providers that are dealing with
8 children and families early on, and our education system to
9 identify kids from birth on, who may be at risk -- I hate to
10 use that term -- may be in a situation where they need some
11 special attention and special following across the course of
12 their lifetime.

13 We have a chance to do what Peter was talking
14 about, which is to start early, do some interventions early,
15 doses of not only interventions, but education for both
16 parents and children in a primary grade setting and follow
17 these young people who may have some predisposition to
18 problems, either mental health or substance abuse problems.

19 MS. HUTCHINGS: Do we in your mind have the data
20 and the information we need to make that argument about the
21 cost effectiveness of prevention? So it is really a matter
22 of messaging and presentation and marketing and customization
23 of audiences?

24 MS. CUSHING: I think I would state it this way. I
25 think we have the information. I don't think the information

1 is packaged correctly. That is the message.

2 Now, Peter is saying, no, maybe we don't have the
3 information. If we don't, then we need to get it,
4 particularly in prevention. Prevention is a hard sell for
5 many people, including our elected officials. If they don't
6 -- they know now about the cost effectiveness of seatbelts
7 and bicycle helmets but they aren't completely sold, I don't
8 believe. Maybe I'm wrong.

9 MS. HUTCHINGS: From a return on investment
10 perspective.

11 MS. CUSHING: From a return on investment
12 perspective.

13 MS. HUTCHINGS: So maybe prevention experts need to
14 get together with data wonks and other health care experts
15 and talk out this conversation, do we have what we need, what
16 is the efficacy of the data, what would the packaging look
17 like?

18 MS. CUSHING: Yes, and not only who should it look
19 like, but how do we package it to make it understandable for
20 the lay public and the policy makers.

21 MS. HUTCHINGS: A lot of you talked yesterday about
22 public education as a theme also.

23 DR. BRODERICK: Cynthia made the case very well
24 yesterday that choices have been made based upon resource
25 availability about the mental health delivery system. It

1 focuses on the seriously mentally ill and excludes quite
2 frankly a lot of mental illness promotion and prevention
3 focus.

4 That is a difficult choice that faces the health
5 care system in general, that when there is overwhelming
6 demand, overwhelming demand, and the need is
7 incontrovertible, it is easy to make the choice to not worry
8 about the setaside for prevention and treat people who need
9 it very desperately.

10 So how to not only make that case to the field, but
11 make that case to decision makers outside the field that an
12 investment is absolutely essential if progress is going to be
13 made. To treat the end stage of disease is to condemn
14 yourself to always treating the end stage of disease.

15 MS. WAINSCOTT: I think one way to make that
16 argument is to talk about the future, not in terms of
17 dollars, but in terms of people. In other words, if we make
18 a decision only to spend our money on the most seriously ill
19 people, we leave them in a system where they continue to die
20 25 years younger, where they go to jail at the rates that
21 they do, those kinds of things happen, and we are
22 guaranteeing -- somebody said the other day, we are cooking
23 up a new batch of people that are going to be sick, and you
24 are.

25 If you can make the argument in terms of the people

1 that we guarantee will be in the system 15 years from now if
2 we don't do that, somehow a shift begins to occur. I think
3 it is hard to prove the dollar thing, but it is irrefutable,
4 it is irrefutable that if we do not begin to do this, we will
5 continue to have this crisis with large numbers of really
6 sick people. You can't argue with that; that is going to
7 happen. So I think that is what we are left with.

8 DR. DELANEY: I think we can talk very clearly
9 that, the impact on the system of not doing it, what it is
10 going to cost in terms of new people into the system, into
11 the seriously mentally ill, that focus, and to just treating
12 the chronically addicted. I think we can absolutely show
13 that.

14 The problem I see with prevention sometimes is, you
15 are kind of proving a negative. And maybe that is the
16 package that we need to look at, the cost effectiveness of,
17 if you do it now, you don't have to do so much in the future.

18 MR. BRAUNSTEIN: When we were at Chesterfield
19 looking at an ever-increasing need for residential services,
20 we had to make some decisions about what we were going to
21 focus on, because we couldn't do it all. We do a lot of
22 residential for people with developmental disabilities and
23 mental illness.

24 What we came up with was that in looking at the
25 market, we saw where there was sufficient resource in the

1 private sector, and instead looked at both ends of the
2 continuum, both those who are disabled by their illness or
3 whatever disability they have, and those who have
4 opportunities to prevent further deterioration. We decided
5 to focus on the two ends of the continuum and let the private
6 marketplace deal with the highest reimbursement area. Let
7 them have that, and focus on the two ends of the continuum.

8 I am saying that as an example of what we have to
9 begin to think about. Putting all these pieces together, it
10 becomes a matter of where can we make the best impact on a
11 population. I would argue that the principles of recovery
12 give us a framework. You have to operationalize those. I
13 think we found a way to operationalize them around quality of
14 life issues, but the fact of the matter is, it has to
15 eventually get down to the ground level and you have to be
16 able to show that you can deliver. We also use principles of
17 prevention in a number of different ways to assist people
18 from becoming further disabled.

19 So I do think that we can do that. I think the
20 conceptual framework is already in place. It is just a
21 question of getting clearer and only focusing on what really
22 needs to be done and not trying to be too many things to too
23 many people. That is one of the points I made yesterday.

24 MS. HUTCHINGS: The prioritization.

25 MR. BRAUNSTEIN: Yes. Let me also comment on the

1 risk thing just real quickly. At the end of the day
2 yesterday, I made the comment that SAMHSA needs to have its
3 internal act together. I said that brusquely and maybe
4 didn't explain it real well.

5 Again, based on my own experience, when I am
6 sitting at the table with a group of agencies like mine, and
7 we begin to talk about going into a crisis, in many cases it
8 is budget crisis but it is also other types, and we start
9 hearing the way people are thinking about it, the people that
10 are thinking about circling the wagons, you know they are not
11 going to be real good partners if you take a risk. When you
12 look behind you, they are not going to be there.

13 So SAMHSA has to be able to show us that they are
14 able to take that step forward and not just leave it, but
15 actually be there when I turn around and say this is where it
16 is going, and I have to see that they are there. The same
17 will be true at the state level. They have to be there
18 taking the risk at their level that I take at my level,
19 putting resources in one place, which means I am going to
20 have some angry people somewhere else saying why aren't we
21 first. In essence it has to be synchronized real well if we
22 take a major step.

23 I have my doubts that it can happen right now, with
24 no derision of the SAMHSA staff. But I have my doubts
25 because of the potential nature of the environment we are in.

1 So that has to be explored at some level somewhere. Maybe
2 it is too late today, but it is an issue.

3 MS. HUTCHINGS: I'm chomping at the bit to maintain
4 my unbiased -- thinking about as a professional field how
5 proud I am of SAMHSA. At a time when support of co-occurring
6 disorders was out there, that peer support and peer
7 specialist support was out there. You're right, every time
8 it takes a tremendous amount of acumen at all different
9 levels to bring out.

10 MR. ALEXANDER: We talked a lot about public
11 education. I think that part of that public education is to
12 understand mental health. I think a large part of why we
13 talk about making mental health par to physical health,
14 people don't understand mental health as they understand
15 physical health. At least, that is my position. And they
16 don't understand -- they may understand the illness because
17 that is what we push, illness. People are coming back from
18 Iraq and they are sick. We have got kids on the street and
19 they are sick, all the sickness.

20 So if we can shift the message to promoting
21 wellness instead of to perpetuate sickness, maybe we can get
22 people on our bandwagon or on our wagon behind us.

23 I believe serious mental illnesses are what people
24 think of when they think of illness, really understanding
25 that there is a continuum of mental wellness. People travel,

1 and they may not be at the same spot. Getting that out to
2 the public, I think that is a part of mental health that we
3 kind of keep to ourselves, don't share with other people,
4 those perspectives.

5 MS. HUTCHINGS: Fran, and then we will transition
6 to the second conversation.

7 MS. HARDING: Just to help support some of the
8 conversation around prevention, Marvin, it is perfect coming
9 right after you speaking, because you touch on an important
10 point, which is language. We talked about this yesterday as
11 well; we have to have the language.

12 I also would say that the cost effectiveness of
13 prevention is something that if we are going to take a risk
14 and get out of the box, it really is something that we need
15 to focus on. I would respectfully disagree with Peter in
16 saying we have the data. The issue is, we are always waiting
17 for the whole piece of the data. I think in prevention we
18 have learned -- and I think we need to take a look at using
19 the data that we have to be able to tell the story that we
20 have to tell, and put it in the language that everyone will
21 understand. So they will understand the breadth of mental
22 illness, they will understand the breadth of substance abuse
23 and be able to apply it and learn what to do with it.

24 We are also forgetting that prevention is
25 multifaceted. There are many different phases of prevention.

1 What most people talk about in public, when they speak of
2 prevention they speak about the individual. It is an
3 individual conversation; how do we get a child to stop using,
4 how do we get an adult not to use in their later life, how do
5 we do this and that to the person. We need to begin to look
6 at what is called a shared environment and look at how we are
7 able to get the message to a broader public. Every other
8 chronic disease does this. That is one of the things that
9 mental health and substance abuse, they are not doing well
10 enough in this country.

11 So I think that we do have the data. We should use
12 what we have. We definitely need more. But we should
13 remember the richness of what we have. I think that we will
14 get closer to what you have been saying for two days, Marvin,
15 and many of us have been talking about.

16 MS. HUTCHINGS: That is a great idea, the shared
17 environment. It seems a natural follow-on might be, Fran,
18 that not only do you capitalize on the data that exists now,
19 but you help articulate what data does not exist and then a
20 pathway to try to capture it in partnership with those people
21 that help with that, right?

22 MS. HARDING: Right. When you focus on a shared
23 environment you are talking about all those partners we
24 talked about yesterday, and needing to bring in all of our
25 collaborative efforts and integrate our work within each

1 other.

2 So it is a necessary step. You can't ignore the
3 other parts of prevention, but when we are talking public
4 education we have got to start looking at the broader public.

5 MR. STARK: When I think about a healthy community
6 or a not so healthy community, I really have to go much
7 beyond just looking at alcohol/drug stuff in the system and
8 mental health and the system. I have got to look at parks
9 and recreation, I have got to look at economic development.
10 I have got to look at what about the extension programs, 4H,
11 other kinds of activities for kids, what about senior centers
12 and other kinds of activities for older adults. It really
13 does get back to looking at that whole broader community.

14 I have seen data that shows that where you have a
15 community that is lacking in activities, doesn't have a lot
16 of jobs, doesn't have affordable housing, a lot of people
17 struggling, clearly you see more problems, alcohol/drugs,
18 mental health, crime. Communities that have a lot more of
19 those resources seem to have a better time of it, meaning the
20 individuals living in that community seem to have more
21 activities, seem to have not as many difficulties, not as
22 many challenges.

23 But what I think we do in alcohol/drug and mental
24 health is, we limit ourselves by not realizing we are part of
25 that bigger whole. Prevention is more than alcohol/drug

1 prevention or mental wellness. It is all of those other
2 activities that are in that community that, when you really
3 look at them, are in fact either things that mitigate risk
4 factors or things that are risk factors. That includes the
5 level of parks and recreation, as I said, 4H clubs, the jobs,
6 the affordable housing. I think that is where we need to get
7 back to.

8 I love the risk and protective factor framework,
9 because it is a great framework. Is it perfect? No, but it
10 is a great framework for being able to go into a community
11 and do some assessment of strengths and maybe weaknesses of
12 that particular community, and then being able to integrate
13 some activities into that community and measure change over
14 time.

15 We haven't done a ton of that in terms of picking a
16 community that is having a lot of problems and going in and
17 assessing from a broad spectrum, not just from an
18 alcohol/drug or just from a crime or just from a mental
19 health, but from a broad perspective assessing that sick
20 community and helping define what are the things that are
21 missing or the things that are there that need to be turned
22 around, and then saturating that community with some fixes,
23 whatever those fixes might be, and then measuring that change
24 in relationship to the health of that community.

25 I think that is where we need to go. That is what

1 is challenging in prevention, because prevention is never
2 given the resources to do that saturation, nor does anybody
3 think about prevention in that broad perspective when we go
4 in to measure the change. We only look at, well, we funded a
5 bunch of community
6 networks, now where is the success, how come things haven't
7 turned around? Well, sometimes we are not measuring the
8 right outcomes, either.

9 DR. GARY: I think Ken just elucidated a clinical
10 example of the social determinants of health. And of course,
11 that frameworks are available. Manmone and Wilkerson have
12 done some very excellent writings. In 1991 I think it was
13 Dalgren and Whitehead who had this model about how one can
14 look at the social determinants of health. That is what the
15 World Health Organization also subscribes to.

16 Again, as I said, we see a patient in the office or
17 in therapy for a minute or for an hour or whatever, and the
18 person goes back to the community. That is the work
19 environment we have to consider. We have to consider early
20 childhood experiences, we have to consider one's behavioral
21 health issues such as the choices that one makes, et cetera,
22 the resources that they have and do not have.

23 The other point I wanted to make, Ken's comments
24 reminded me of it. I thought about it yesterday, but I
25 forgot to say it. I think as we move toward this upstream

1 model and embrace a public health agenda, we somehow have to
2 look at having public health as a stakeholder. We do have
3 infrastructures in every county in the United States in
4 public health, and somehow I think we need to dialogue about
5 how we can use the public health infrastructure that now
6 exists to push our agenda.

7 Public health departments have very defined
8 missions. A long time ago, one of those missions was mental
9 health. It was not the treatment of disease, but it was
10 prevention. That has long been eroded in public health
11 departments.

12 So I think a very serious conversation will have to
13 take place about how we are going to interdigitate with
14 public health departments that have an infrastructure in the
15 community and address other social determinants of health.

16 MS. HUTCHINGS: Fran, you mentioned in the phone
17 interview the book, *The Social Determinants of Health*, a new
18 book. Who was the publisher, do you recall off the top of
19 your head?

20 DR. GARY: It is the Oxford Press. I will send you
21 the rest.

22 MS. HUTCHINGS: I have it. I just have it in my
23 notes.

24 DR. GARY: There are other very excellent articles.
25 I can send you a whole reading list about the social

1 determinants of health.

2 MS. HUTCHINGS: Good. I am going to Italy
3 Thursday, so not until after.

4 DR. GARY: I'll have them waiting for you.

5 MS. POWER: I thought that if you took a look at
6 all the comments yesterday that we were bold. We were bold
7 in the sense that if you took the vision statements and you
8 made strategies and operationalized them, there was some
9 pretty risky and bold work in that.

10 MS. HUTCHINGS: I think you defined leadership
11 yesterday too, if I recall. You said it is this act that
12 comes, followed by these action steps.

13 MS. POWER: Right. So it seems to me that if we
14 could -- and I think that boldness in and of itself helps
15 build the sense of urgency. I do believe it is important for
16 people, with all the messaging issues. But I think what we
17 lack in terms of taking that bold step are these very
18 concrete examples of what we mean.

19 I worked with the federal partners for four years
20 on the issue of primary care and behavioral health
21 integration for four years, with very, very smart people, and
22 they are not sure where to go. On a scale and scope issue,
23 we can find centers of excellence, but on a scale and scope
24 issue they are not sure where to go.

25 So the reality is that if we mean by integration

1 the primary care and mental health and substance abuse
2 condition nexus, that is one thing. If we look at a public
3 health approach that is another umbrella that we talked about
4 yesterday, that is another thing. So what do we choose? Do
5 we find communities and go after a bold program that then
6 state leadership can point to and say, yes, we are taking
7 risks and we think this is the way to go?

8 We have to define that layered approach. The
9 public health orientation, is it primary care and mental and
10 substance abuse conditions coming together and pushing that,
11 and do we do that by working with other public health
12 agencies? Do we do a concentrated leadership approach? I
13 think there is a boldness in that. I think it is a matter of
14 layering it and getting that message right, and SAMHSA can
15 take that leadership position. I really believe that.

16 MS. HUTCHINGS: The last word.

17 DR. HUMPHREYS: A couple of things. This is a good
18 discussion. On the safe thing, I would say that in mental
19 health and the addiction field, because it is a stigmatize
20 endeavor we tend to undershoot what we can do.

21 If you will indulge me for a very short story, I
22 was on a friend's porch here in Washington with a group of
23 mental health people at the very beginning of the election.
24 I think there were like 200 people running for President. We
25 were saying, I hope whoever wins, I hope they have some

1 interest in mental health. There was an experienced lobbyist
2 there who laughed and said, do you think when bankers get
3 together they say, I hope the next President is interested in
4 banking? No, they say, who are we going to get behind and
5 what are we going to do and how are we going to make this
6 President work for us?

7 So tie that into how do you create a sense of
8 urgency. We are very close to an election. We are going to
9 have a new President and a new Administration. There needs
10 to be a galvanizing event at that level. We had the mental
11 health commission, a lot of good things came out of that from
12 this Administration. There is going to be a new one. This
13 agency, but also more generally the recovery movement needs
14 to be reaching out to whoever the President is, whoever the
15 First Lady is, whoever the key people are, and say we need a
16 galvanizing event. Maybe it is a White House conference on
17 untreated mental illness and addiction in the United States.
18 Maybe it needs to be a march on Washington, something like
19 that. It takes that level with all the cacophony of issues
20 to say, this is going to be on the map of the next
21 Administration.

22 MS. HUTCHINGS: That is a nice transition to the
23 second part. Let me check in with you, I think it is page
24 eight, the capturing of the set of bullets from the second
25 conversation from yesterday, creating and sustaining a

1 recovery oriented system of care.

2 As you looked at the first set, were they
3 reflective of your contributions, your input yesterday? We
4 are going to ask the same question. By the way, you just did
5 a fantastic job of these key themes from yesterday. Same
6 question, what were the key themes that as you looked this
7 over, as you thought about it, that came up from that part of
8 the conversation?

9 DR. LEHMANN: Just one comment about both of these,
10 because I am a notorious lumper. One of the things is, there
11 are a number of -- there are about 30 or so of these things.
12 One thing that we might do in looking at this is lump them
13 into some things.

14 MS. HUTCHINGS: The summary will certainly do that.

15 DR. LEHMANN: There is a public health model, a
16 financing model. It is just something to think about to make
17 the message more easily --

18 MS. HUTCHINGS: We ran out of time last night, is
19 the truthful answer. The other thing is, I wanted to see
20 what you would pick as some of those key themes, and you did.
21 Some of the ones you just identified came up as natural
22 points that you made yesterday. So a great observation,
23 thank you.

24 MS. WAINSCOTT: I'm a lumper. I enjoy lumping.
25 Wellness is a big theme, which again brings you to a

1 continuum.

2 MS. HUTCHINGS: How about definitions, but not too
3 far down the road of defining? That is what I heard. Let's
4 not get carried away with over definitions that people can't
5 fit into, find their own interest in, and then we lose people
6 along the way. So we need to get a sense of what we are
7 talking about, asking for, but not overdoing it, which I
8 thought was some sage advice.

9 Daryl, any thoughts occur to you from yesterday?

10 MS. KADE: I was nodding about that, because we are
11 not a research agency, we are a services agency. I think
12 even if we could have people self identify as recovering and
13 develop a baseline that we could track and refine over time,
14 it would be a very, very powerful statement about the whole
15 nation in recovery and where we want to go, which fits very
16 well into the previous theme and maybe the galvanizing
17 element that you need to bring people together. Again, not
18 defining it too much but at least concertizing it so that
19 people can see the people.

20 MS. POWER: One of the things that I noticed about
21 the recovery conversation was that we I thought were all very
22 eloquent about recovery itself and the process of recovery
23 and the journey of recovery, and how we have all taken that
24 and made that a part of our work.

25 But I don't think we went to the next level, where

1 we were actually talking about getting to the creating and
2 sustaining systems of care that then would connect to those
3 outcomes that we could report on. So there is another level
4 of discussion that needs to be had.

5 Coming from the back end, we talked about the
6 second generation of NOMS and what is the next generation of
7 national outcome measures that will get us more closely to
8 what Daryl is talking about, because that is a wonderful
9 message. But then backing that up even further, what do we
10 do about taking on this responsibility of helping to create
11 and sustain recovery oriented systems? We don't do that in a
12 very direct way.

13 I am going to use a particular state as an example.
14 We know the communities and states that are working on state
15 recovery oriented systems. I know that sitting at this
16 table. We don't go after those that don't.

17 So to me, the issue is, why aren't we doing that?
18 In other words, we are giving grants to people who are
19 competitive enough to win the grant, but we are not going
20 after those communities and those states that we know are not
21 doing recovery oriented work.

22 If I were a business and I would want to develop a
23 market, I would go after that market.

24 MS. HUTCHINGS: How could you get to that?

25 MS. POWER: I'm thinking that I am going to change

1 the whole way about technical assistance and the way we do
2 business around technical assistance. I am going to go
3 invite myself. I figure that is the only thing I can do, and
4 get my staff to thin about inviting themselves. We sit
5 around and say so-and-so is not doing X, and they could
6 benefit from doing Y, and why don't they have a community
7 approach in this state, and we sit around and talk about
8 that, but we don't go after it.

9 So to me, there is a shift that we might think
10 about in having to get to coordinating and creating and
11 sustaining systems that are recovery oriented that are much
12 more directive, even if I am not getting direction from my
13 board of directors and Congress I could use the resources we
14 have to be much more specific about helping that happen. So
15 that is my response from yesterday in our recovery
16 discussion.

17 MS. HUTCHINGS: It seems to me that SAMHSA is and
18 can even further more be helpful in, here is a checklist for
19 a state program, whether it is recovery oriented. One of the
20 things that we didn't talk about yesterday is what does it
21 look like not to be recovery oriented, so you know in part,
22 once you hopefully create and sustain a recovery oriented
23 system at whatever level.

24 Your point yesterday, we do know enough about what
25 some of this looks like, to help pull that together and let

1 them assess themselves, so we do cultural competency in
2 organizations before we finally use that as a way to move it
3 forward.

4 MR. STARK: Let me play the devil's advocate on
5 that. I agree with your conversation and your statements,
6 Kathryn, but let me play the devil's advocate just for a
7 second.

8 Let's say you wanted to go in that direction. We
9 have defined a recovery oriented system, and SAMHSA has
10 decided that it has these list of criteria that will say,
11 this state or this state is not following those principles.
12 You have got now some sanctions or some incentives or
13 disincentives that you can apply, and you have the backing of
14 HHS and the SAMHSA director and Congress to move forward with
15 that.

16 The big challenge for you is going to be that given
17 the principles that you have defined, can you truly show that
18 a state that meets those principles compared to a state that
19 doesn't has better outcomes? If you can't, you are going to
20 commit suicide politically.

21 So it begs the question of going back to our
22 earlier discussion of really making sure that SAMHSA and the
23 other federal partners are able to collect data to show what
24 is or isn't working and where is it or isn't it working.

25 MS. POWER: I agree. I'm not trying to put SAMHSA

1 in a position of doing sanctions on anybody. That is not the
2 approach that I would encourage. I don't believe in that.

3 The issue for me is, in yesterday's discussion we
4 didn't get to that point, where we said how are we going to
5 build capacity for recovery oriented systems. Given the
6 restraints from resources, we can't multiply everything. I
7 don't have the transformation dollars for every state, so how
8 are we going to help that?

9 I'm going to use the state of Washington as a
10 transformation state and learn from what they have done and
11 make that available to other states in terms of strategies.
12 That is really what I mean. There is a replication effect
13 and an exponential multiplier effect that we could be using
14 that I don't think we are using.

15 There is good data for 30, 40 years, that if you
16 have an assertive community treatment approach you are going
17 to have better outcomes. There are states that still don't
18 do that, and that is a shame.

19 MR. STARK: One quick final comment. I agree with
20 that. I was hoping you were going to get to the next step,
21 because I would go for the sanctions and incentives and
22 disincentives, if I truly believed I had enough ammunition
23 and had done that education and marketing.

24 MS. HUTCHINGS: Speaking like a guy who just left a
25 state position.

1 MR. STARK: I actually did do that in Washington.

2 MR. BRAUNSTEIN: I just want to reinforce what
3 Kathryn said. I think that is an excellent strategy.
4 Furthermore, it is not just about outcomes. That is
5 important, but it is not just that. It is also that you need
6 to do it the right way. So it is also about process.

7 There are some processes that are empowering to
8 people, which is what recovery is all about, than principles
9 are. Yes, you can keep your hospitalization rate down, and I
10 worked in managed care, I can keep the hospitalization rate
11 down by just denying the heck out of it and shifting the cost
12 over to the medical system through emergency room and so
13 forth.

14 So don't get lost in some of those traditional
15 measures of effectiveness, because you are right, you will
16 get caught in a political maelstrom. I think it is about a
17 mix of process and outcome measures, and it is about -- at
18 SAMHSA's level it is about sending a very strong consistent
19 powerful message, not a recipe, but a fairly clear set of
20 guidelines, that this is how it needs to get done. There are
21 a lot of different ways that you could get there, but you
22 need to be on this path. If you are not on this path you are
23 not getting it done right in a way that it will be sustaining
24 for the people that you are there to serve.

25 MS. HUTCHINGS: We have believe it or not blown

1 through an hour, almost. So very, very quick comments.

2 MS. KADE: Very quick comment, picking up on what
3 Kathryn had mentioned. What we had discussed was a
4 combination of program specific and population specific data,
5 that you could track the immediate impact of your programs
6 along with the trend in population. Like what Fran was
7 saying, this is a shared community, so the outcomes are
8 shared, and there are a lot of different contributors. So
9 the policy discussion is not only our contribution, but
10 everyone's contribution within the context of population-
11 based trends. That way you have a more global agenda and you
12 are partnering. And you may even have shared performance
13 goals.

14 MS. HUTCHINGS: Imagine that.

15 MS. WAINSCOTT: Quickly, I want to endorse
16 Kathryn's go after them idea. When you have people in states
17 where it is not happening, people suffer. I think it is our
18 job to do that, so I am very supportive of that.

19 But I would propose hitching to it the idea that
20 you had yesterday of the leadership academy. If you come and
21 go and there is nobody there prepared to follow up with the
22 consumer voice, it is likely to be shoved under the table.

23 The other thing that I would suggest we think about
24 in answer to your implied question about what hammer do we
25 have to show that we are doing any good on this, and that we

1 should go back earlier.

2 Can we count, Peter, I ask you this, the reduction
3 of disability as a serious outcome of early stream work?
4 Does anybody do that? In my life, I know that when people do
5 not get what they need early, they often end up disabled, and
6 when they do they are like my granddaughter, they are
7 successful in school.

8 DR. DELANEY: I think it is just a question of
9 coming up with a plan and doing it, to be honest with you.

10 MS. WAINSCOTT: There are some measures we are not
11 using.

12 MS. HUTCHINGS: Before you go, let's put you on the
13 spot. Is there anything you want to contribute? I know we
14 missed you yesterday, but in this conversation so far? I
15 just want to give you an opportunity. Don't feel compelled.

16 PARTICIPANT: Thank you for the opportunity. The
17 discussion is something that obviously is very important. We
18 have been promoting all of the strategies that you are
19 talking about except for the compulsory part. So we are very
20 much interested in seeing where this dialogue is going, in
21 the primary care system, recognizing the social determinants
22 of care in both the mental health and substance abuse arena,
23 particularly criminal justice, child welfare and the physical
24 health aspects, are all very much interactive. We will work
25 with the rest of SAMHSA to make sure that we achieve these.

1 In a period of transition, some of these issues we
2 need to be somewhat cautious about, because we can't
3 transcend our basic mission, some of which is codified in the
4 statute. So we need to keep that in mind.

5 One of the things that I would approach you to do
6 is to review the statute that creates us, and therefore it is
7 something that OMB and the Hill points to when they tell us
8 what we can and cannot do.

9 MS. HUTCHINGS: Within your authority. Terry, can
10 you do it in 30 seconds?

11 MR. CROSS: One of the things that we talked about
12 yesterday is the issue of partners and convening. I can't
13 emphasize enough the need to reach beyond HHS and cross the
14 border, particularly to Department of Commerce. I think
15 there is major leverage there with what all of this costs our
16 society, and the ways that we deal with that.

17 In tribal communities, we are seeing things like
18 the nation's building model working effectively. When an
19 economy is transformed in a tribal community, health gets
20 better. The North Carolina Eastern Cherokee is one of the
21 county sites where there is a national longitudinal data
22 gathering process going on around the well-being of children.

23 If you look at the tribal economy, it developed, and the
24 mental health of the children and families in the community,
25 they ran parallel and increased. As the tribal economy got

1 better, the county economy got better. So not only did
2 tribal children benefit from an improved tribal economy, but
3 the non-tribal children in the county benefitted.

4 MS. HUTCHINGS: The whole community.

5 MR. CROSS: So this conversation needs to happen at
6 a much broader level. We need to go outside the bounds of
7 mental health and substance abuse.

8 MS. HUTCHINGS: Two tasks. I want to bring us into
9 the second. One is to check the parking lot; there is
10 nothing there. Secondly, this list of Rick's priorities
11 from yesterday morning that you articulated can be served so
12 well by the conversation that you had over the last day,
13 suicide prevention, substance abuse treatment gap, 18 to 24-
14 year-olds, veterans behavioral health needs, indigenous
15 peoples. What a wonderful set of priorities that can be
16 informed and hopefully buttressed by some of this
17 conversation, too.

18 Besides checking in with the last comments, I want
19 to let you know what an absolute pleasure it was to listen
20 and learn from you yesterday and this morning, and to thank
21 you very much for having me. Rick, any final?

22 DR. BRODERICK: Thank you for leading us through
23 that very stimulating conversation over the last day and not
24 quite a half. It is always a pleasure to be in the company
25 of people who think critically and offer comments and

1 thoughts from multiple perspectives on a topic that is so
2 critical to us all and has great currency.

3 So what happens now, I guess is the question that I
4 will ask on behalf of the group, in terms of what we will do
5 with the information, how we will next see the information
6 and take it to the next step.

7 MS. HUTCHINGS: I am going to move from lumper to
8 articulate categorizer. My deliverable is to submit back to
9 my GPOs, Mark Weber, Jennifer, Toian, a summary in some sort
10 of fashion of trying to organize the input from yesterday and
11 this morning. Then after they take a peek, that will come
12 out to the entire group for comment, input, did I get it
13 right, et cetera. Then that will be finalized as a document
14 that it is anticipated you would use with ELT and other
15 colleagues in SAMHSA, is my understanding.

16 I'm not sure exactly about the time frame. I am a
17 little bit vacation challenged. I am going to go on this
18 one, make it work.

19 DR. BRODERICK: Please do go, enjoy yourself. But
20 in any case, I would ask that you as a Council reflect upon
21 the conversation when you get the document from Gail. Feel
22 free to comment on it, and we will look forward to a document
23 that we will have a discussion about at an upcoming ELT
24 meeting.

25 So thank you all for the thoughts that you

1 contributed to this very important topic, these two very
2 important topics.

3 At this point, we are at the point in our agenda
4 where I get to have the great privilege of introducing Dr.
5 Kevin Hennessy. You may recall from our March Council
6 session, there was some interest articulated by the Council
7 in better understanding evidence based practice and the
8 National Registry of Evidence Based Practice. Kevin is the
9 Director of our Science and Service Program, so we have
10 invited him to spend about 30 minutes with us today, talking
11 about NREBPP and how one qualifies to have an evidence based
12 practice listed there and the mechanics thereof.

13 So, Kevin.

14 **Agenda Item: Update on SAMHSA's National Registry**
15 **of Evidence Based Programs and Practice**

16 DR. HENNESSY: Thanks very much. It is a real
17 pleasure to be back among and with the Council. I appreciate
18 the opportunity to address you again about SAMHSA's National
19 Registry of Evidence Based Programs and Practices, and to
20 show you at least one significant change that we have made
21 based on the input that you provided to me back in March when
22 I last spoke with you.

23 The main feature, to use a movie analogy, the main
24 feature today is NREBPP of the next half hour. However, I
25 want to show you a coming attraction. That is something that

1 we are working on.

2 My understanding was that among the rich discussion
3 yesterday, there was a little bit of a discussion about
4 workforce development issues. So I want to just highlight
5 for you something that is in development currently within
6 SAMHSA to address some workforce development issues, and make
7 SAMHSA's role much more visible.

8 This is a prototype screen shot of a home page of a
9 new Web portal that is in development. It is called SAMHSA's
10 behavioral health workforce information network. Up in the
11 left-hand top corner you can see the icon. Again, it is a
12 prototype.

13 One important way that SAMHSA is beginning to address some of
14 the workforce development challenges across the country.

15 You will notice across the top you have got blue
16 tabs all the way across the top. These are the major
17 functions of this new Web portal. The job search will be a
18 direct link into a major Internet job registry, so there will
19 literally be thousands of jobs that you can search by state,
20 locality, type of position.

21 In addition to the major Internet provider or Web
22 based job registry, there will also be icons to link directly
23 into the job registries of many of SAMHSA's major
24 stakeholders, the American Psychological Association,
25 National Association of Social Workers, NCCBH, NAMI, you name

1 it, different things.

2 I am just highlighting this briefly because I do
3 want to get on to NREBPP, but the second functionality or
4 professional requirement, you will be able to search by state
5 and by discipline, by position, by courier type, the kinds of
6 professional requirements that are needed. So students,
7 those in the field that are maybe interested in moving into
8 behavioral health can get a sense of what kind of licensing,
9 professional requirements, training requirements do I need if
10 I want to be a social worker in Iowa or a psychologist in
11 Hawaii or an addictions counselor in Florida, or a prevention
12 specialist in Montana.

13 Training rotator. If I am interested in moving
14 into the field, I need to know how I can go about getting the
15 training that I need. So it will be everything from formal
16 graduate programs all the way down to online courses, and
17 everything in between. You will also be able to search by
18 discipline and by state on that, and by locality.

19 Tool kits are things that are in development within
20 SAMHSA around recruitment and retention, core competencies,
21 some different kinds of tool kits that will be available.

22 Events calendar is to highlight many of these
23 training events all across the country by discipline and by
24 particular area, and finally a virtual library that will
25 contain a plethora of various documents, best practices and

1 recruitment and retention and core competencies, lots of
2 seminal articles about workforce development, different
3 information sharing.

4 It will be a place -- the vision for this Web
5 portal is that it is a single place where people can go to
6 get much if not all of what they might need to get started in
7 the field or to continue to progress in the field, wherever
8 their place is in the behavioral health and mental health or
9 substance abuse field. They can come here as a first stop,
10 and hopefully be directed to the places and get the
11 information that they need to progress in their field and to
12 achieve their career goals.

13 This again is a prototype. We have worked very
14 closely with Mark Weber and his staff in the Office of
15 Communications. We are hopeful that this will be a live
16 working Web portal within the next several months. My
17 optimistic hope is that it may be something that we move out
18 in the next month or so, something maybe akin to the American
19 Public Health Association meeting or something like that.
20 But we are working on these details. But I just wanted to
21 give you a snapshot of something that I think is pretty
22 exciting that we have in development. I think we will begin
23 to meet many of the needs of the field in the workforce
24 development area.

25 Let's shift to NREBPP. This is just going to be a

1 brief overview, and then I am going to get back into some of
2 the progress that we have made, based upon your input.

3 The NREBPP overview. We had the new website that
4 was launched about a year and a half ago. It is a searchable
5 online registry of mental health and substance abuse
6 interventions that have been reviewed and rated by
7 independent reviewers. Its major goal is to assist the
8 public in identifying approaches to preventing and/or
9 treating mental or substance use disorders that have been
10 both scientifically tested, that is on the one hand, and
11 that can be readily disseminated.

12 So there is this balance. We want good science,
13 but we want easy disseminatability, or at least the ability
14 to disseminate many of these interventions much more broadly.

15 This is a resource where people can be able to
16 assess these programs to see the goodness of fit, how well do
17 they fit their needs and their particular resources.

18 This is again a screen shot of the home page. We
19 will be going to the website in a couple of minutes to show
20 you one or two functionalities that are new.

21 The background on this is that the NREBPP publishes
22 and posts an intervention summary for every intervention that
23 is reviewed. That summary contains an array of descriptive
24 information.

25 Two different forms of ratings that are rated by

1 experts, quality of research, how well is it researched, how
2 well is it conducted, how confident can you be that the
3 results of these interventions are actually the result of the
4 intervention and not something else, and then a readiness for
5 dissemination rating. That is how well are the materials
6 developed, how well is the training developed, so that these
7 interventions can be brought to scale.

8 It also includes a list of studies and materials
9 that were submitted for review, and contact information for
10 each intervention developer and/or dissemination staff.
11 SAMHSA plays the middle person in all of this. We are really
12 about trying to pair the community based providers and the
13 states and localities with some of these interventions, so we
14 are very much encouraging people to move toward the program
15 developers if they have additional questions.

16 That is a very busy screen shot of what one of the
17 intervention summaries looks like.

18 I had an opportunity to do a year one operations
19 report, or at this point 18 months operations report, since
20 we launched the website in March of 2007. So as of 8/31/08
21 we had 106 interventions that had been reviewed with
22 summaries posted on the website.

23 We have an additional roughly 125 interventions
24 that have been accepted for review; 38 of those are currently
25 under review, they are in some form of the review process,

1 and then additionally we have 88 that are pending. They have
2 been accepted for review and we have yet to get to them. The
3 review has not yet commenced.

4 If we break that out by center, you can see it is
5 fairly evenly distributed, both interventions that have been
6 posted to the website, those that are under review and those
7 that are pending review across all the three centers. The
8 three centers are our major investors in this NREBPP system.

9 Without them, we would not be able to conduct this work, so
10 we very much appreciate their contributions to this effort.

11 The summary of operations. Seventy-one of the 106
12 interventions, roughly 67 percent, were developed and/or
13 evaluated with support from the National Institutes of
14 Health. This really underscores one of SAMHSA's major
15 commitments in this area, and that is the importance of
16 delivering upon the science. We are taking the science that
17 is produced particularly through the National Institutes of
18 Health and we are delivering it much more readily and much
19 more visibly, and hopefully in a way that is much more easily
20 implemented by the public.

21 The new NREBPP website has generated a fair amount
22 of support and interest among agency stakeholders. We had
23 about close to 250,000 Web hits over the past 18 months, and
24 it represents a little over 200,000 unique visitors.

25 We have had two open submission periods. The first

1 was October of '06 to February of '07. You can see the
2 numbers there, 53 submitted, 35 accepted for review. The
3 second year we had more submissions, 68, and more accepted,
4 46. So overall we have increased by 28 percent just in one
5 year the number of submissions, and 31 percent the number of
6 acceptances.

7 In addition we have added -- this system you may
8 recall was based on an older model program system that began
9 in substance abuse prevention, and we provided a very nice
10 foundation for what we have subsequently done. We moved many
11 of those programs in, grandfathered them in as legacy
12 programs.

13 What I would like to say is, to put this in a bit
14 of context in terms of investments that we are making. The
15 research investments in the development and evaluation of a
16 single intervention by the National Institutes of Health or
17 others oftentimes can range from one million to five million
18 dollars or more. Overall, the NIH budget is approaching \$30
19 billion, so we are putting a lot of money into the
20 development of research. Spending approximately one to
21 two percent of this amount, which is what we do for NREBPP,
22 to conduct a comprehensive and objective review of the
23 evidence to support this intervention appears to be a
24 worthwhile and justifiable investment. Rather than spend all
25 the money and then have the end product be a journal article

1 or a series of journal articles, we are trying to take this
2 and make it alive and useful and valuable to the public. So
3 spending one to two percent of the overall research
4 investment in these efforts seems very worthwhile, at least
5 to me and I hope to you.

6 The next steps for NREBPP. The contractor
7 anticipates completing reviews for approximately 40 more
8 interventions, resulting in about 150 that will be posted
9 before the contract concludes roughly this time next year.

10 We will be recompeting the contract for another
11 five years. Approximately 90 interventions have already been
12 accepted and they will remain in the queue for review under
13 the new contract.

14 Let me put a quick plug in for the contractor,
15 Manilla Consulting Group, because they have just done an
16 outstanding job over the past five years in transitioning to
17 this new system and now getting us up and running under the
18 new system.

19 I think I see Dr. Steve Gardner, who is a program
20 review manager for Manilla Consulting Group, Steve, if you
21 can stand up, and a former CSAP employee, I might add. Then
22 next to him is Dr. Gary Hill, who is the project director for
23 NREBPP. They have both been invaluable to this effort.

24 To conclude just the overview part, we have
25 completed the successful expansion of NREBPP based on the old

1 model program system. The initial feedback has been very
2 positive from the public. Finally, our continued support for
3 this is important, and we look to the centers and hope to
4 grow both in visibility and value to the field in years to
5 come.

6 That is the quick overview, to get you back up to
7 speed on NREBPP. What I do want to show you is a little bit
8 of the change, one addition that we have made to the system.
9

10 The Council had made a recommendation, or at least
11 we had some discussion, last time about searching and
12 identifying interventions particularly that were either
13 developed for or evaluated primarily with one or more
14 minority populations. There was some feedback that the way
15 the system was set up and the search functions, it was a
16 little difficult to do that. So we took that to heart, and
17 we made some improvements.

18 This is the search page. This is how you would
19 search at this point among the 107 different summaries. We
20 have enhanced the search function for race and ethnicity. We
21 have basically made it quicker to identify interventions that
22 were primarily developed for or evaluated with a particular
23 population. So what we have done is, if you click on any of
24 these race or ethnicity buttons, you will see that it drops
25 down and it says, to specify a percentage of the study

1 population that was viewed.

2 The default for this is at least 50 percent. So
3 among the studies that were reviewed to include as part of
4 the intervention summary, at least one of them had, at least
5 50 percent of the population was this particular group. So
6 if I do a quick search on that, you will see four
7 interventions, not exactly where we want to be, but that are
8 -- they are not, and I don't know what that was. But this
9 functionality allows for an ever-expanding search, so you
10 ended up with four interventions. But if you increased the
11 criteria to allow a broader search of at least 25 percent of
12 the population to be included in one or more of the studies,
13 you will see that you get 25 interventions.

14 Again, I am doing this very quickly for time
15 purposes. If I expand it to any of the studies in the
16 database that included Hispanic or Latino populations in one
17 or more of the studies, then it expands to 75 interventions.

18 So you can see you can customize this search much more
19 effectively to get at populations that you are interested in.

20 If you have one or more of the studies that
21 includes this population, let me show you for example under a
22 different minority category. Fourteen interventions that had
23 at least 50 percent of the population was black or African-
24 American. I am going to click on motivational interviewing
25 just to show you. If I jump down to study populations, you

1 can see that of the five studies that were included for
2 review for this intervention, the first study is 82 percent
3 white, 18 percent unspecified. But then if I move down, you
4 can see that study four is 60 percent black or African-
5 American. That is why it is coming up in the database. That
6 is why it is one of those 14 that hit when I did the search
7 on at least 50 percent, was because of that study four. It
8 doesn't mean that every single study will be majority of that
9 population, but it does mean that if you are looking for
10 interventions that have been evaluated with that particular
11 population, you will be able to do that much more efficiently
12 with these new search criteria.

13 One quick thing that I wanted to mention. If you
14 search within a category, the search logic is an "or". So if
15 you click on for example, if I am interested in black or
16 Hispanic and I am going to get studies, you will recall that
17 when I searched on Hispanic 50 percent it was four studies.
18 When I did the same for black it was 14 studies. If I do the
19 search now with black or Hispanic, I get 18 studies. So it
20 is an "or" logic; it includes both black or Hispanic.

21 If I am searching across categories, meaning that I
22 am looking for interventions that have been tested with
23 blacks or African-Americans, and I am also looking for age
24 group, a particular age group, then the search logic is
25 "and", meaning it is going to be smaller. It is those 14

1 interventions, but of those 14, how many of them were tested
2 with a six to 12-year-old population. So you will see that
3 you come up with three interventions.

4 So I just wanted to highlight that the search logic
5 behind that within categories is "or", you are going to get
6 more studies within a category. If you are going across
7 studies, you are going to get less studies, because it is
8 going to grab only those that are in the African-American and
9 the six to 12-year-old range. So that is just a quick
10 overview of that.

11 This really was driven by the comments that Council
12 made, so I thank you very much for providing that input. In
13 some ways I look forward to the input that you are going to
14 provide perhaps today.

15 That was touching upon one of the recommendations
16 that Council had made to us in terms of enhancing the ability
17 to efficiently search for interventions for particular
18 minority groups. The other recommendation or other part of
19 that recommendation was around how can we improve some of our
20 ability to identify and encourage submission of these
21 interventions. I just wanted to have a brief discussion with
22 you about some things that we are doing to try to enhance our
23 ability to identify and encourage diverse submissions.

24 The first is that the contractor is conducting some
25 literature searches. We just completed one in the substance

1 abuse treatment area that had an additional benefit of --
2 many of those major journals that we had the contractor
3 search also identified substance abuse prevention
4 interventions. So we have culled the literature for the last
5 eight to ten years to identify some of the best
6 interventions, or at least the most rigorous interventions in
7 both substance abuse treatment and substance abuse
8 prevention. We will be able to identify which of those are
9 targeting particular minority populations and hopefully
10 encourage some of those submissions directly to the registry.

11 We can also and have in the past put special
12 emphasis within the annual Federal Register solicitation
13 notices. Every year or most every year, we go out with a
14 Federal Register notice, encouraging developers to submit
15 their interventions to NREBPP. We can highlight, and again
16 have in the past, but can maybe even be more explicit about
17 this, highlighting and encouraging submissions for particular
18 interventions that have been tested or developed for
19 particular minority groups.

20 I think we are also finding increasingly, and this
21 is a very welcome development from my perspective, that we
22 are getting the support of SAMHSA's TA centers, particularly
23 the Native American center for excellence, a component of
24 their statement of work, the work that they are going to be
25 doing over the next several years is try to identify

1 interventions that were developed by the Native American
2 community, and maybe moving toward NREBPP as one outcome.

3 Also, the CAPs and the ACCTs have been very
4 important partners. We are excited about continuing to work
5 with them. The CAPs in particular, the service and science
6 component of the CAP work is critical to continuing to move
7 innovative programs toward helping them develop an evidence
8 base. So we are very grateful from my perspective for the
9 work that the CAPs are doing in that area.

10 I think we can also look to try to have more
11 engaging discussions with the National Institutes of Health
12 regarding their health services research portfolios. Quite
13 frankly that is challenging, but it is something that we
14 certainly can try to pursue with them, in terms of
15 influencing or at least trying to identify and work with them
16 to impress upon them the importance of beginning to make
17 investments in interventions that are developed primarily for
18 particular minority groups.

19 So those are some of the things we have within our
20 purview of being able to do to continue to address some of
21 the Council's recommendations in this area.

22 Five minutes. I am right on the mark for
23 questions. I know I presented a lot of information. You may
24 have some questions about some of this, or some additional
25 questions. But thank you for the opportunity to address you.

1 It was a wonderful opportunity. Last time we got some good
2 input. If you have any additional input you would like to
3 give us, I'm all ears. Thanks.

4 DR. HUMPHREYS: Could you clarify, does NREBPP only
5 include programs that meet the criteria for review? Or do
6 you also report when you have reviewed something and
7 concluded that it is not effective?

8 DR. HENNESSY: There are three minimum requirements
9 for us to consider a review. One is that it has an outcome
10 that it is statistically significant at the traditional
11 level, P .05 or less. It is an outcome that is in the mental
12 health or substance abuse area.

13 A second is that there is some sort of
14 documentation about the intervention, be it a journal article
15 or series of articles, or even a grant final report.

16 The third minimum requirement for consideration for
17 review is that there are materials and trainings available.
18 We are not only interested in the science, we are interested
19 in making sure that we can take these things to scale.

20 So those are the three minimum requirements. You
21 can see from my submission statistics that not everything
22 gets accepted for review that gets submitted. Of the things
23 that are accepted for review, we generally post an
24 intervention summary on all of those reviewed interventions.

25

1 The only time we wouldn't, and again this speaks to
2 the voluntary nature of this system, is if a program
3 developer does not agree to the posting of that intervention
4 summary, then we will not post it. We work with them and
5 impress upon them the investment that is being made by the
6 government and by taxpayers in this review process. So we
7 generally are fairly successful at converting the
8 interventions. Even those that maybe they have concerns
9 about the posting, we have been virtually 100 percent
10 successful in getting them to agree to the posting. So that
11 is our goal.

12 MR. CROSS: I want to thank you for addressing the
13 search issue. I think an equally important issue is the
14 nature of the way the search was arranged before. I'm not
15 sure that the fix would sell, but particularly when you can
16 search more broadly, there is a possibility of the promotion
17 of bad science rather than good science.

18 Is there any notation of the limitation of those
19 studies that have a small percentage of the minority
20 population that is included, as not necessarily being
21 relevant to that community? There is a need that we
22 discussed here before to make sure that what is being
23 represented, people can judge for themselves, but I think
24 that there needs to be some notation of limitations.

25 DR. HENNESSY: I agree with you. One of the

1 overarching goals of the system is to provide information as
2 objectively and validly as possible. We do that through
3 these intervention summaries.

4 In terms of the limitations or the weaknesses,
5 generally -- and I could go back in there to show you, but
6 you can do it too -- there are sections after each of those
7 criteria, the scores on the quality of research and the
8 readiness for dissemination. There are narrative sections,
9 strengths and weaknesses.

10 Sometimes they would highlight particular studies.
11 Other times it is more general statements about the
12 weaknesses of the intervention and/or the strengths. But
13 again, what we are trying to do is highlight for the public
14 the important or critical information about the intervention,
15 and then they are the ultimate judges of, given their
16 circumstances is this a good fit for me, or should I talk to
17 the developer more.

18 MR. CROSS: My concern is that the people who are
19 looking at these things are not scientists. They are policy
20 makers, they are bureaucrats, often people who are writing
21 contract language for RFPs, people who are writing
22 legislation. So unless it is made clear, if this is a
23 resource for the public, and how you are defining public is
24 not the scientific community or necessarily the practitioner,
25 I think it is important to give some summary of what the

1 science means for people and at what level they can depend on
2 the science to be what they think it is.

3 The consequences are really dramatic out there. I
4 don't know how much you know of how this is being used, but
5 states and local governments, private funders, are limiting
6 their funding to things that are on your list. That is
7 making it so that tribal communities and rural communities
8 cannot give funding to programs where those restrictions are
9 in place.

10 The other thing that is happening is that
11 corporations, and some of them are major defense contractors,
12 are buying up these because they are on your list, and states
13 and counties are restricting access to those, and it has made
14 it so that rural communities are no longer able to afford to
15 purchase that evidence based practice.

16 So in one way you are limiting the market, and it
17 seems unfair and certainly an unintended consequence that by
18 having corporations buy up evidence based practices that are
19 then limited on your list and then charging for them when the
20 government has already put in one to five million dollars to
21 make them evidence based, it seems like we need to think
22 about, is there a way to create a regulatory function that,
23 if you are going to make it on this list you have to make it
24 affordable for every community.

25 If we have got a vision for SAMHSA that every

1 person can live safely in their community, and they ought to
2 be able to receive the treatments that have been affirmed by
3 the federal government as evidence based at a price that any
4 community can afford.

5 I just want to raise that issue here, because I
6 don't think SAMHSA wants to be in the business of filling the
7 pockets of contractors at the expense of people, children and
8 families in our communities.

9 DR. HENNESSY: Thanks for your comments. Let me
10 summarize with a couple of things. I think I would probably
11 respectfully disagree with you on a few things, and I am
12 going to point out what that is.

13 I think we were acutely aware of what is happening
14 out there, which is why we have been very explicit. Unlike
15 the old system, the model program system, which we were
16 silent on many of these issues, if you go to the home page
17 and you click on using NREBPP, and we put it in bright yellow
18 because that is where we would like people to go first, we
19 put some guidelines up there about how we think the system
20 should be used and how it shouldn't be used.

21 You will see those bullets. It is the first step
22 to promote informed decision making. That is the top bullet.

23 Then we provide questions that we think people should ask
24 developers. I won't click on it now in the interest of time,
25 but they are straightforward plain language questions saying,

1 these are the kinds of things you should be peppering
2 developers with to find out if this program is a good fit for
3 your particular circumstances.

4 We also provide language about what the ratings
5 are. Then third, we say we do not provide an exhaustive list
6 of interventions or endorsements of specific interventions.

7 If you look at that second to last bullet, policy
8 makers and funders in particular are discouraged from
9 limiting contracted providers and/or potential grantees to
10 selecting only among NREPP interventions. We know that there
11 were problems in the past. That is why we put that language
12 up there. When I give presentations, most of the time I
13 mention this specific bullet, because I want people to be
14 able to go right to the website and to show funders, no, that
15 NREPP itself is explicitly stating this is not how the system
16 should be used. So I think we are really trying very hard to
17 make sure that this is a fair system and that we are actually
18 enhancing peoples' options for choice.

19 Now, in terms of the proprietary issue, there are
20 different schools of thought on that. One of the things that
21 we have done, and again to show you real quickly the search
22 page, you can search on a lot of different characteristics,
23 one of which down here at the bottom, the materials and the
24 intervention components are public or proprietary or a mix.

25 The reality is, many of these interventions are a

1 mix of these things, and sometimes people are spending a fair
2 amount of money at the state or local level on an
3 intervention that is not particularly effective, or it
4 certainly hasn't been demonstrated to be effective. We are
5 saying that among the choices that people can make, they
6 should have an opportunity to choose interventions that meet
7 their needs the best, in terms of choosing the kinds of
8 outcomes they want to achieve.

9 Some of these interventions are going to be
10 proprietary, the reality is. But if they are making
11 investments of \$10,000 or \$15,000 or \$20,000 and not getting
12 any results, then maybe they should consider one of the
13 interventions that is roughly the same cost, but that has
14 demonstrated its ability to achieve some of those outcomes.
15 And it has a support staff at the developer level to provide
16 them with ongoing implementation support and training and
17 those kinds of things that are needed to successfully
18 implement the intervention.

19 So that would be a response to some of the concerns
20 you have raised. I think SAMHSA is sensitive to them and has
21 built in some things into the systems to address some of
22 those.

23 MR. CROSS: Thank you for pointing out that. I
24 think it is one thing to try to mitigate unintended
25 consequences. My sense is that those unintended consequences

1 are much more profound in my community than they are sitting
2 here looking at this. We have programs that can't get
3 funding because the only evidence based model that the
4 funding will fund is not relevant to our community, and owned
5 by one of those proprietary interests.

6 So it is not a criticism of you or what you have
7 tried to do. I admire what you are trying to do. I
8 seriously believe in science to practice, and this is an
9 important step to get there. But I do think we need to --
10 and the reason I raise it here at the Council is that it is
11 beyond the programmatic level of NREBPP. It is a national
12 policy issue, about how do you regulate the content or the
13 performance and what is available to people.

14 It really is a matter of access in our communities.
15 You run the risk of excluding community based, culturally
16 based practices. We had a good presentation here at the last
17 Council about culturally based practices and the importance
18 of inclusion of those items in the list of available
19 practices. So these are dilemmas that are important policy
20 decisions that we have to make.

21 So you can't fix it at the level of the website.
22 It is a much larger policy discussion. Thank you.

23 DR. HENNESSY: Thanks. There were a few other
24 questions.

25 MS. KADE: I just wanted to point out, this

1 operation is run through my office. What we haven't done is
2 to monitor the extent to which states and communities have
3 been using NREBPP in perhaps an inappropriate fashion. I
4 know this came up in tribal consultations in Montana. I
5 think that is something that we could follow up on.

6 DR. HUMPHREYS: I would say there is a Catch-22
7 problem that I think Terry is putting his finger on. When
8 you have a population that hasn't been studied very much, you
9 can't do evidence based practice, because there is no
10 evidence, and you can't get the evidence until you practice.
11 So you have to do something and then study it.

12 I view this failing actually as being an NIH
13 failing primarily. SAMHSA is the consumer and disseminator
14 of this information. Some of the Institutes have not done a
15 very good job of making research in mental health and
16 addiction demographically representative. That is why we
17 have this chicken and egg dilemma that we are in.

18 DR. GARY: I just wanted to follow up on what Terry
19 said and also what Keith said. I applaud this website. I
20 think it is excellent and very, very useful. Thank you, and
21 thank SAMHSA.

22 I think I have a more basic philosophical yearning
23 to say that when we look at science, back to Keith's notion,
24 when we look at science, when I talk about evidence based
25 practice to people I work with in the community, they say to

1 me, whose evidence? They want to know who were the principal
2 investigators, how were the principal investigators trained,
3 how were the people who decided that this what excellence is,
4 what do they know about me, what do they know about my life
5 experiences. And you can get something statistically
6 significant and it has no meaning to me at all. But somebody
7 says that this is excellent and this is the intervention that
8 should occur.

9 So I think there are moments for many disconnects,
10 simply because of the way science is manufactured. So I
11 think we have to begin with an NIH issue: How is this science
12 produced, how are these discoveries made, and who makes the
13 interpretation about what the data says. That is very
14 frightening to me.

15 Then it comes to the service piece. When we look
16 at service, my question is, how does service inform science?

17 I think there needs to be another loop, once we get beyond
18 the statistically significance of the data and it goes to the
19 community, we have to have a method of determining how
20 science can inform science, how the service can inform
21 science.

22 I get very concerned about these statistical
23 findings and people who determine that it is statistically
24 significant for my community and for the people that I serve.

25 I think there is always a connection there, and there is no

1 method in the system to make that correction. So I think
2 that it is very important.

3 The other question I have is, do people in the
4 communities who have been studied and where these
5 interventions take place, do they ever get a chance to
6 critique these interventions and what they mean for them? An
7 intervention has a life. It might work for the first six
8 months or the first three months? Does it work for a year
9 later? Does it work for two years later, three years later?

10 And how can we have any data that determines the impact of
11 these interventions over what period of time? So do they
12 make a difference in communities, or do we need to have
13 boosters that last for five, ten, 15, 20 years?

14 So even though I think this is an excellent
15 beginning, when I look at what happens on the ground with
16 peoples' lives, I think we need to have some other kinds of
17 safety nets built in, and especially look at how service can
18 inform science. I don't think science always knows. I think
19 science does the best that it can, but science makes some
20 very, very huge flaws that affect peoples' lives. We see it
21 in communities every day.

22 DR. HENNESSY: Thank you for those comments. I
23 know there has been some initial movement within the NIH
24 world to recognize those very points you are making. You
25 critically need to have the services communities beginning to

1 influence the scientific community. Those on the Council
2 that are tied into NIH more, maybe Keith and others, may be
3 aware of some of those additional activities.

4 But I think SAMHSA's role -- and it really is a
5 bidirectional activity, science to service and service to
6 science -- we can try to provide where we can a conduit for
7 stakeholders to be able to provide some of that guidance to
8 the Institutes. Hopefully they will be receptive to that
9 guidance. But I think you are right, we need to step up
10 efforts to try to do that. So I appreciate your comments.

11 MR. ALEXANDER: As one of those things that you can
12 do, can you put a link on there for practice based evidence,
13 those things that are service that we know work? For
14 instance, we know wraparound works, but it hasn't been
15 through the test of time, or wherever there is a group of
16 people who certify this is an evidence based practice. Is
17 there a way to recognize those practices that we know work?
18 We know wraparound works. So is there a way to put it on
19 there? It is not evidence based, it has not been through the
20 test, but is there a way for SAMHSA to recognize that we know
21 that there are things that are not evidence based practices
22 by definition, but they work?

23 DR. HENNESSY: In some of these practices there is
24 an emerging evidence base. One of the programs that we have
25 in the queue for review is illness management and recovery,

1 Mary Ellen Copeland's recovery program. There are some other
2 things that we have in the queue that speak to that as well.

3

4 So I think it is a combination of trying to
5 identify where there is evidence of some of these types of
6 programs, particularly the recovery programs, and try to move
7 those into review for NREBPP, and in other places maybe
8 looking at, as you said, if there are particular websites or
9 places where they are highlighting some of this practice
10 based evidence that is also critical in terms of filling out
11 the continuum of our evidence base, then maybe looking to
12 ways we can highlight that.

13 DR. BRODERICK: If we could take Judy's comment and
14 Ken's comment, then we need to move on.

15 MS. CUSHING: Just very quickly following up on
16 something that Terry raised that is of serious concern, and
17 one that perhaps NAC should take up as an agenda item in the
18 future. That is the question about evidence based practices
19 and the fact that funders, state legislators, policy makers
20 look to you in these evidence based practices as the gospel
21 truth.

22 There is science around and there are a lot of good
23 reasons, but in rural frontier communities and culturally
24 diverse communities, it is very, very challenging, just as
25 Terry raised. So the community is between a rock and a hard

1 place. They cannot afford the evidence based program. The
2 evidence based program may not fit their population, but the
3 legislature in order to be funded is requiring them to use
4 that program.

5 So I hope that there will be much more research and
6 investigation about the conundrum that has been created in a
7 number of states and communities around this.

8 DR. HENNESSY: It is a good point. I think part of
9 the challenge for SAMHSA, and this is maybe a leadership role
10 for us, is trying to educate the states and the localities
11 about how to use the system and some of the downsides or
12 maybe even the dangerous consequences of limiting choices
13 that way.

14 Again, we have got stuff all over the website,
15 explicit language discouraging that. So I feel like we are
16 trying to do what we can. Part of it is maybe making sure
17 that others -- and we don't have total control over that, in
18 some cases very little control. But we can try.

19 MR. STARK: I'll jump in with Kevin. I am not
20 asking for a response, so don't worry about that. I am also
21 wanting to state that I think you have done a great job on
22 that website. I do think that any website that is out there,
23 particularly one that is listing evidence based practices, is
24 going to be abused. You can't help that. It is just going
25 to happen.

1 What does get to me is that fascinating nexus
2 between the art of science, politics and the whole issue of
3 capitalism in this country. That is really what we are
4 talking about here.

5 When I was at the Millhouse transformation project,
6 we attempted to do an inventory of evidence based practices
7 for mental health and alcohol/drugs. We actually did do that
8 inventory as part of the transformation project. It is on
9 the website for Washington State's mental health
10 transformation project.

11 We found nine different sources like this, NREBPP
12 being one, that listed evidence based practices. We
13 struggled with how we were going to decide what we included
14 in that list in the report. We finally, after much
15 discussion like is going around here, decided that we will
16 put in any program that made it to three of those nine sites,
17 just arbitrary, very artistic, scientific sort of decision,
18 based on a certain amount of capitalism and political
19 pressure.

20 So we produced that report. I think you all are
21 going to have the same kind of struggle. But it gets back to
22 what we talked about earlier today, and particularly
23 yesterday, and that is, where are we at including the Council
24 and SAMHSA, in making sure that we are educating those MCSL,
25 NGA, NACCO, remembering that these elected officials and/or

1 their staff go to these national conferences and listen to
2 all kind of different experts present all kinds of different
3 stuff, talk about evidence based practices and what works.
4 Then they go back to their states, Oregon, and pass laws and
5 say, you can't get money from us if you don't meet these, or
6 Washington or Texas or whatever.

7 So I think it is really going to be incumbent upon
8 all of us to really start paying attention to how we can get
9 on those agendas to educate those governors and their staffs
10 and those county executives and their staff and city
11 executives and their staff and those state legislators and
12 their staffs, when they have those events. It is not just on
13 evidence based practices, but on the broader stuff that we
14 have talked about the last day and a quarter.

15 **Agenda Item: Closing Remarks**

16 DR. BRODERICK: Thank you. Thank you, Kevin, for
17 that presentation. Needless to say, evidence based practice
18 and its application remains to be something we will continue
19 to talk about and look at, achieving the balance that I think
20 you all are making the case for.

21 At this point, our formal agenda is concluded. I
22 want to thank you all. I will keep my closing remarks brief
23 since we have run a bit over, but I felt it was more
24 important to have this conversation than you hear me talk
25 about how great the meeting was.

1 I will also say that we will convene in ten minutes
2 next door for the kickoff of the Recovery Walk, for those of
3 you who would like to join us. The weather looks a bit
4 ominous, but I hope that the rain will wait for us for an
5 hour or so, so we can conclude this. If not, we will still
6 have the event next door. So please join us there.

7 Toian has some dates for our next Council meeting
8 that she will share with you electronically. Also we would
9 be interested in your opinions about this venue and its
10 utility for future Council meetings. We would also be
11 interested in your suggestions about agenda items for our
12 next Council meeting. So if you give that some thought and
13 respond to Toian when she writes to you electronically, I
14 would greatly appreciate it.

15 Thank you all for coming, and we look forward to
16 seeing you outside. Oh, I need a motion to adjourn.

17 MR. ALEXANDER: Before we adjourn, I remember Dr.
18 Gary asking at the last meeting about our next meeting, which
19 will be this meeting, happening at an Indian reservation
20 perhaps. What happened with that?

21 DR. BRODERICK: We have a Council for travel
22 affairs as well. They have partnered with a number of
23 different agencies to have their Council meeting in Billings,
24 Montana several weeks ago. The logistics were very
25 difficult, given our situation with hotel contracts and the

1 like, to do that.

2 But her recommendation is still on the table, and
3 we will look for that opportunity. We have some six months
4 now to plan. Before, that session had already been
5 scheduled.

6 MR. ALEXANDER: But we are still considering it?

7 DR. BRODERICK: Yes, correct. Terry I know will
8 help us with that. Motion to adjourn has been made and
9 seconded. Motion accepted. Thank you very much.

10 (Whereupon, the meeting was adjourned at 10:20

11 a.m.)

12