

**Minutes of the 46th Meeting
of the
SAMHSA National Advisory Council**

September 25, 2009

Portland, Oregon

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

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Minutes

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council convened for its 46th meeting on September 25, 2009, at the Hilton Executive Suites Hotel, Portland, Oregon. Eric Broderick, D.D.S., M.P.H., Acting SAMHSA Administrator, chaired the meeting.

Council Members Present: Marvin C. Alexander, L.M.S.W.; George Braunstein; Judy Cushing; Faye Annette Gary, Ed.D., R.N.; Thomas A. Kirk, Jr., Ph.D.; Kenneth D. Stark; Flo A. Stein, M.P.H.; Cynthia A. Wainscott; and Edward K.S. Wang, Psy.D. (see Tab A, Council Roster)

Council Member Absent: Hortensia Amaro, Ph.D.

Council Executive Director: Daryl Kade, M.A.

Designated Federal Official: Toian Vaughn, M.S.W.

Non-SAMHSA Federal Staff Present: 4 individuals (see Tab B, Federal Attendees List)

Representatives of the Public Present: 32 individuals representing 22 organizations (see Tab B, Public Attendees List)

Call to Order and Traditional Opening

Ms. Toian Vaughn, Designated Federal Official, SAMHSA National Advisory Council, called the meeting to order at 9:10 a.m. on September 25, 2009.

Welcome, Consideration of the Minutes from the April 2009 SAMHSA Council Meeting, and Opening Remarks

Dr. Eric Broderick welcomed attendees and announced that Council member Keith Humphrey, who now serves as a policy advisor at the Office of National Drug Control Policy (ONDCP), has resigned from the Council. Council members approved the minutes of the April 22, 2009, Council meeting.

Dr. Broderick explained that a new SAMHSA Administrator has not yet been named, although the selection process is progressing. He noted that 617 community and media events were held during Recovery Month 2009, and at a news conference with the ONDCP Director R. Gil Kerlikowske, SAMHSA released the 2008 National Survey for Drug Use and Health (NSDUH) data.

Dr. Broderick noted that Secretary of Health and Human Services (HHS) Kathleen Sebelius has focused on healthcare reform, H1N1 influenza, regulation of tobacco by the Food and Drug Administration, HIV/AIDS, food safety improvement, and implementation of the American

Recovery and Revitalization Act. SAMHSA has identified its priority cross-cutting issues as passage of Parity Act regulations, recovery efforts in the aftermath of the economic downturn, National Drug Control Strategy implementation, veterans' concerns, and issues related to children and families. Dr. Broderick noted that, in collaboration with the Departments of Treasury and Labor, HHS plans in the coming months to publish parity regulations; at the time of the Council meeting, all pending healthcare reform bills incorporated parity measures. SAMHSA advocates for inclusion of mental health and substance use services in a reformed system. Dr. Broderick explained that ONDCP has amplified its emphasis on demand reduction, and 20 SAMHSA staff members have worked to develop the National Drug Strategy.

SAMHSA National Advisory Council Policy Think Tank

Dr. Faye Gary, Ms. Cynthia Wainscott, and Dr. Thomas Kirk discussed a new framework to enable the Council to enhance its contributions and facilitate SAMHSA's work. In its national leadership role, SAMHSA can play a major part in healthcare reform and sustaining fiscal stability—and the Council can help by suggesting policy directions and approaches to the design and delivery of services, and metrics that can measure the progress of systems transformation. Connecticut, for example, now focuses on a healthcare business plan to use dollars more effectively and to control the growth of costs.

Discussion. Dr. Broderick noted the need to emphasize performance-based systems, especially in view of the current budget process and the Administration and Congress's expectations of prudent use of funds and program accountability. SAMHSA is well positioned because of its Centers' existing tracking and accountability systems. Council members and SAMHSA leaders suggested the following high-priority topics as potential targets for think tank focus:

- National Drug Control Strategy
- Homelessness prevention and amelioration, particularly by developing the case that investment in skill building and treatment for elementary school-age children represents prevention of homelessness
- Education, given that this is an interdepartmental priority collaborative between HHS and the Department of Education
- Focus on identifying local communities' best practices for broader dissemination
- Support for SAMHSA's strategic and operational planning, particularly in devising strategies to work collaboratively across agencies and to foster program continuity
- Global burden of disease
- Strategies to address the epidemic of school dropout

Dr. Broderick responded positively to Mr. Stark's suggestion that SAMHSA investigate the interest that other agencies' national advisory councils may have in convening a joint meeting with SAMHSA. The think tank discussion was tabled until later in the meeting.

Healthcare Reform in Oregon: Implications for Children, Youth, and Their Families

This panel described Oregon's landmark efforts to ensure that quality health care is accessible and affordable to everyone in the state. Dr. Alan Bates, Oregon Senate Majority Whip, stated that Oregon's legislature has expanded access to health care and changed the delivery system to reduce costs. Following negotiations with insurance companies and the hospital association, the

legislature enacted a provider tax expected to yield \$3.5 billion over 4 years earmarked for healthcare, including mental health and substance abuse treatment. Within 12–18 months, every child is expected to be insured, and Medicaid will expand slightly, while cutting costs.

Oregon foresees electronic medical records for everyone, with a focus on integrating information among physical, mental health, and substance abuse partners, as well as with housing, education, and court systems. Oregon plans to develop an all-payer, all-claims database to identify costs and anticipates changing how the state pays its providers, moving away from fee-for-service to team approaches that incorporate integration, outcomes, and best practices. Oregon has two pilot projects to integrate mental health and physical health, and will focus in the future on drug courts. Dr. Bates noted that the state's beleaguered psychiatric hospital system has improved, but asserted that addressing mental health and substance use issues locally in order to avoid incarceration for criminal behaviors is critical.

Dr. Mitch Greenlick, Member, Oregon House of Representatives, advocated addressing problems with funding treatment for mental health and substance abuse by ensuring that all have access to health insurance. Oregon's advances include establishment of the Oregon Health Authority—a single state agency that integrates healthcare, including mental health, substance abuse, and public health—and on merging the purchasing power of the state to buy healthcare for dramatically larger numbers of people.

Dr. Bruce Goldberg, Director, Oregon Department of Human Services, and Director-Designee, Oregon Health Authority, described the complexity of the current service reimbursement system that is designed to follow funding streams and policy, but lacks a standard payment schedule for equal services and uniform standards for the health outcomes of those services. The goal is to use data to drive elimination of disparities in health and access, and to create uniform standards to enable treatment for everyone with the same high quality of mental health and substance abuse care, regardless of who pays for it. Oregon is beginning with the 30 percent of people for whom the state is directly responsible. Dr. Goldberg asserted that prevention and population-based health, not tertiary services, are essential to contain costs and improve health. It is essential to integrate public health and individual health systems to address obesity, tobacco, and other substance abuse, which now drive down quality and raise costs in the rest of the system. He noted the need to create accountability by providers and consumers. He pointed out that Oregon has an opportunity to create true parity of quality, access, and payment.

Mr. Joe Finkbonner, Executive Director, Northwest Portland Area Indian Health Board, noted that the Kaiser Family Foundation, in a recent brief on health disparities, notes that 33 percent of American Indian/Alaska Natives (AI/AN) lack health insurance, approximately twice the rate in the general population. He pointed out that these populations endure poverty, disproportionate rates of chronic conditions, and an epidemic of suicide among young people. The Indian Health Service is funded at 50 percent of the level of need, and for Indian tribes, the largest growing segment of their budget is healthcare. Mr. Finkbonner highlighted the need for a healthcare system that preserves the values, principles, and priorities of the current Indian health system, and urged forging Federal partnerships with AI/AN organizations. He noted the importance of the Children's Mental Health Initiative, including Circles of Care; funding for community-driven

projects that feature community health representatives; and the successful Cancer Navigator Project as a model to assist people address other chronic conditions.

Discussion. In response to questions from Council members, panelists further described Oregon’s emerging healthcare system. Dr. Bates noted that Oregon’s provider tax on revenues of hospitals and private insurers triggers Federal matching dollars. A strategy, Dr. Greenlick added, that will generate \$1 billion for the biennium. Dr. Goldberg stated that Oregon is working to create more primary care access points, including expanded school-based health centers and Federally Qualified Health Centers. The state also is considering accountability of healthcare organizations, community-based organizations, and the provider community for health, funding, access, and outcomes. Dr. Bates asserted the need to pay providers adequately for primary care.

Mr. Stark pointed out the need to reimburse for outreach efforts to bring people into care with mental health and substance use issues. Dr. Goldberg observed the need to learn from managed care’s mistakes and focus on how to bring people early into the “right care” and to create appropriate incentives. He concurred with Mr. Braunstein that other systems can generate cost offsets, noting that because 60 percent of children in the child welfare system are there because their parents have untreated mental health and substance use problems, shifting resources from child welfare to substance abuse treatment would create cost offsets. Housing and other community supports factor into this discussion; one cannot have mental health without a place to live. Oregon will convene a group to consider how treating people for a treatable addictive illness can create offsets in schools and in the criminal justice system. Mr. Alexander noted the need for attention to the social determinants of health, public education, and outreach to engage people in culturally competent care that does not perpetuate historical trauma.

Dr. Gary identified the need to integrate strategies to improve healthcare quality and reduce disparities in accordance with Healthy People 2010 and 2020 indicators, and to address workforce issues. Dr. Goldberg concurred with the need to develop metrics and to move those metrics in the desired way, for example, to address disparities. Dr. Bates described an elementary-school mentoring program that stimulates interest in the healthcare professions, aimed in part to develop a culturally representative workforce. Dr. Greenlick advocated for training and licensing across disciplines and professions for home health aides.

Children, Youth, and Their Families: Conversation with Center and Office Directors

Senior SAMHSA leaders described their activities that focus on children, youth, and families. Dr. Anna Marsh, Deputy Director, Center for Mental Health Services (CMHS), stated that CMHS’s major programs include the Children’s Mental Health Initiative; Circles of Care; Healthy Transitions; National Child Traumatic Stress Network; Safe Schools/Healthy Students; Garrett Lee Smith Youth Suicide Prevention for states, tribes, and campuses; and Project LAUNCH (Linking Actions for Unmet Needs in Children’s Mental Health). Dr. Marsh also described positive outcomes of selected programs as measured by CMHS’s Transformation Accountability (TRAC) System. She noted that a 2009 Institute of Medicine Report, “Preventing Mental, Emotional, and Behavioral Disorders Among Young People,” offers an important mandate for future prevention efforts.

Ms. Frances Harding, Director, Center for Substance Abuse Prevention (CSAP), explained that CSAP funds the Substance Abuse Block Grant, Strategic Prevention Framework–State Incentive Grants (SPF-SIG), underage drinking prevention grants in collaboration the Department of Justice’s Office of Juvenile Justice and Delinquency Prevention, STOP Acts, Drug-Free Communities Program, a large number of HIV/substance abuse prevention grants, and the Young Adults in the Workplace Program. Ms. Harding stated that CSAP’s new SPF-SIG follow-up grant program, “Partnerships for Success,” offers incentives to successful SPF states to enhance their performance measurement activities. She noted that CSAP is working with ONDCP and other agencies to address the need for coordinated prevention services nationwide.

Mr. Richard Kopanda, Deputy Director, Center for Substance Abuse Treatment (CSAT), explained that while less than 10 percent of CSAT’s portfolio is specifically targeted to children, youth, and families, this remains a high priority area of emphasis throughout the general CSAT portfolio. Targeted programs include Pregnant and Postpartum Women (PPW), Assertive Adolescent and Family Treatment Grants, Juvenile Drug Courts and Family Dependency Courts, and National Center on Substance Abuse and Child Welfare. Mr. Kopanda described program demographics and positive program outcomes. Future CSAT directions include increasing treatment operations, better use of evidence-based practices, treatment targeted to PPW or family-directed programs, and Screening, Brief Intervention, Referral, and Treatment (SBIRT).

Dr. Peter Delany, Director, Office of Applied Studies (OAS), SAMHSA, discussed data on children and youth collected in SAMHSA’s three major data systems: NSDUH, DAWN (Drug Abuse Warning System), and DASIS (Drug and Alcohol Service Information System). Of the approximately 68,000 people interviewed annually, about a third are between ages 12 and 17; they answer the same questions posed to adults, plus questions on risk and protective factors. Dr. Delany explained that SAMHSA has sufficient parent-child pair sets to investigate the relationship of youth substance use to substance use of parent or guardian, the correlation between depression of the parent and the youth, and the correlation between substance abuse and mental health disorders among siblings. SAMHSA is working to make public a great deal of data, including a series of “States in Brief” publications, including one on adolescents and another on children, that look at trends and context. Another series will look at specific health disparity factors in terms of ethnicity, and still another series will cover data on 25 metropolitan areas. SAMHSA plans to build its analytic capacity with new survey staff who will survey new communities. OAS is also working with the National Association of State Alcohol/Drug Abuse Directors (NASADAD), the National Association of State Mental Health Program Directors (NASMHPD), and the Community Anti-Drug Coalitions of America (CADCA) to find ways to help states and communities use data to drive policy and programming. Dr. Delany reported that the DASIS contract has been renewed for 7 years. He stated that a new approach to defining abstinence and to creating a recovery measure is emerging.

Discussion. Dr. Delany replied to Council members that state reports currently are posted on SAMHSA’s Web site, and that he will inform members when metropolitan reports are available. Ms. Wainscott urged publication of more data on children with mental illnesses. Dr. Marsh noted that increased collaboration between CMHS and OAS has resulted in more questions in NSDUH on prevalence of mental health disorders.

Substance Use and Mental Health Services for Youth and Their Families: Juvenile Justice Perspective

Dr. Laura Burney Nissen, National Program Director, Reclaiming Futures, and Associate Professor, School of Social Work, described the Robert Wood Johnson Foundation's (RWJ) Reclaiming Futures initiative to approach substance abuse among adolescents as a primary healthcare issue. She noted the great cost of juvenile justice involvement compared with treatment and pointed out that although many new and effective treatment models have been developed in recent years, bringing them to scale in communities has not occurred. The Reclaiming Futures initiative promotes more treatment opportunities, treatment tailored to the needs of diverse groups of young people, transitional and aftercare services, and positive youth development options involving increased community capacity.

Three years ago, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and CSAT invited RWJ to pilot a variation of the Reclaiming Futures model with an enhanced juvenile drug court framework that addresses systemic reforms. The model involves the following components: screen and assess youth appropriately with evidence-based tools, involve families, coordinate care across and between disparate human and justice services, monitor that young people engage in and complete treatment, and follow-up with transitional care. Dr. Nissen noted, however, that many young people are screened away from drug courts who cannot access quality care because of lack of capacity, the nature of their offenses, or other reasons. She added that the Urban Institute's evaluation of the program demonstrated its effectiveness, and RWJ's intention is to make it available to every community.

Hon. Deanne L. Darling, Judge, Clackamas County (Oregon) Juvenile Drug Court, observed that in juvenile justice courts, judges have a profound ability to effectuate change in a short period of time. By the things they say, judges can motivate people to change and to convene systems for change. The National Council of Juvenile Justice Family Court Judges provides training in problem solving, but, Judge Darling asserted, if children were removed from the juvenile system and efforts were focused on the needs of families, greater success would be achieved. She advocated for partnerships between the juvenile justice and child welfare systems to provide wraparound services; integrated treatment for mental health, substance use, and physical ailments; and addressing trauma competently. She emphasized the importance of individual and family therapy, and noted the difficulty in adequately funding and sustaining those essential services. Judge Darling stated that few decent treatment programs exist either for girls or for people of diverse cultures and languages. She noted the importance of praising individuals who have emerged from court supervision. She asserted that while judges want to be part of the solution, a community-based solution is needed that permits courts to be courts—and not problem-solving mechanisms.

Discussion. Ms. Wainscott noted the need to provide juvenile courts with referrals. Ms. Cushing urged SAMHSA to consider funding training for juvenile court judges on how to speak to young people to elicit positive outcomes. Ms. Flo Stein emphasized the importance of community partnerships in addressing treatment for adolescents. Dr. Nissen added that RWJ has a curriculum for judges and is working to increase the level of Federal partnerships to make it universally available.

Public Forum

Ms. Beckie Child, President, Mental Health America of Oregon, described her organization's activities, including receipt of a Consumer/Survivor Networking grant, hosting the 4th Annual Frontier Leadership networking conference, and publishing newsletters. Challenges and barriers to treatment include inadequate public transportation, poverty, and distant treatment facilities. Ms. Child described the David Rompley Warm Line, which enables people to talk to a person if they are having difficulties or feel lonely, but which is experiencing funding difficulties.

Mr. Corbett Monica, Board Member, Mental Health America of Oregon, and Founder and Executive Director, Dual Diagnosis Anonymous (DDA), described the importance of peer support groups for both substance abuse and mental health problems. He founded DDA to enable people with symptoms of mental illnesses to participate in a 12-step program. DDA in Oregon conducts 450 meetings monthly in 30 of Oregon's 36 counties that are attended by 3,000 people, including meetings in hospitals and other institutions. He asserted that until both addiction and mental illnesses are addressed equally, people will not stay clean.

Discussion. Panelists responded to questions from Council members. Mr. Monica explained that DDA welcomes children at most of its meetings, enabling DDA to serve as part of a continuum of recovery services. Ms. Child encouraged funding the warm line through the block grant to avoid the need for Medicaid participation to receive its services. She noted the warm line's cost-effectiveness in responding to early help seeking—and perhaps avoiding the need for more expensive services later.

Ms. Maija Yasui, Hood River County (Oregon) Prevention Coordinator, noted the uniqueness of Oregon's focus on convening siloed agencies to discuss how to report and measure program effectiveness, using common language. She noted the value of SAMHSA's support and training in mobilizing communities, and described local successes in sharing and blending funding streams, staffing, and facilities across boundaries. Ms. Yasui pointed out that the Pacific Northwest Providence Health Care System intends its 14 hospitals in Oregon, Washington, Idaho, and Alaska to take a comprehensive, integrated health and prevention approach.

Bob Richards, Treasurer, National Association of Alcoholism & Drug Abuse Counselors (NAADAC), asserted the need to take care of the people who provide services. He expressed appreciation for SAMHSA's support of addiction treatment and Recovery Month, and he urged attention to homelessness and an anticipated surge in the need for public-sector services as combat veterans return home.

Council Roundtable Discussion: Think Tank

Dr. Gary, Dr. Kirk, Mr. Alexander, and Mr. Cross volunteered to spearhead the think tank. For its first effort, it will identify core concepts of effective programs that involve multiple systems change. Council members planned to consider the business case and to identify incentives to facilitate implementation of local programs with potential for other geographical areas or populations. Council members may volunteer to identify appropriate programs with which they are familiar. Ms. Stein noted that the ability to select from a menu of effective, cost-effective options may generate greater buy-in when community partners establish collaborations. Dr. Broderick suggested that the Council identify potential areas for resource transfer and that

SAMHSA's discretionary portfolio may help identify areas where this shift now occurs. Mr. Cross suggested that SAMHSA's technical assistance centers and other contracted experts make recommendations, and then ask the Council to review their conclusions. Dr. Kirk stated that he plans to examine how SAMHSA's Mental Health Transformation SIG, Access to Recovery, and SPF-SIG initiatives have contributed to systems change. Dr. Larke Huang identified several intergovernmental collaborations (i.e., Project LAUNCH, innovative educational programs in Atlanta's public and Indian housing, and the 4-H substance abuse prevention initiative) and asked the Council for guidance in describing these efforts in terms of the business case.

Council members highlighted the linkage of stable housing to prevention and positive outcomes in individuals' recovery. Ms. Stein suggested partnering with the Department of Veterans Affairs on this issue. Mr. Stark noted that housing—even when unaccompanied by treatment—reduces emergency room and other costs. Mr. Braunstein urged SAMHSA to promote this strategy.

Dr. Kirk and Mr. Stark both observed the importance of programmatic flexibility. Mr. Stark suggested extending the SBIRT model into the mental health arena. Dr. Kirk advocated for bundled rates that offer incentives to address persons' multiple needs. Drs. Broderick and Marsh acknowledged the Council's recommendation for SAMHSA to be less prescriptive and more flexible in structuring its grant programs.

Council members suggested that the think tank focus on systematically addressing the needs of special populations. Ms. Wainscott urged a focus on integrating the public health approach and mental health and substance use issues into healthcare reform, and suggested that members share information from the field about programs and possible opportunities.

Ms. Wainscott urged SAMHSA to promote planning for prevention in order to reduce demand for hospitals and crisis units, and to frame funding for substance abuse prevention in a way that assertively promotes substance abuse prevention's simultaneous—but currently tacit—role in preventing mental illnesses and building resiliency. Mr. Stark concurred, stating that by dropping the term *substance abuse*, prevention dollars also would address mental health, teen pregnancy, school runaway, and juvenile justice; he urged SAMHSA to review its Centers' programs to capitalize on mutually beneficial activities. Ms. Cushing urged SAMHSA to continue its focus on mental health, treatment, and prevention. While cautioning against losing a focus on substance abuse prevention, Ms. Harding endorsed incorporating the core of prevention—the logic model of strategic planning for each community—in developing programs. She encouraged a focus on programs that work with juvenile justice and criminal justice, and on investigating SBIRT's usefulness in schools and among high-risk youth.

Mr. Stark suggested convening Federal agencies with intersecting interests to brainstorm on maximizing resources. Ms. Cushing endorsed SAMHSA's outreach to its Federal partners and urged greater intra-SAMHSA activity and communication. Council members highlighted additional concerns related to SAMHSA's mission: educational efforts; collaboration to reduce silos; consideration of school dropout rates as a public health problem; social determinants of poor health, including poverty and school failure; and early intervention and treatment for people with mental health disorders.

Closing Remarks

Council members suggested locations for the next Council meeting, including Boston, Cleveland, Atlanta, and Rockville, MD. Dr. Wang noted that the choice of city should include consideration of site visits that coordinate with the agenda. Mr. Stark suggested that a spring Rockville meeting might include a presentation by an ONDCP official of the to-be-released National Drug Strategy. Ms. Wainscott stated that an Atlanta meeting could incorporate interactions with the Centers for Disease Prevention, the Carter Center, and innovative consumer programs.

Adjournment

The meeting adjourned at 6:00 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

January 26, 2010
Date

/s/ _____
Daryl M. Kade
Executive Director, SAMHSA National
Advisory Council, and Associate
Administrator for Policy, Planning and
Budget, SAMHSA

Minutes of the September 25, 2009 meeting will be formally considered by the SAMHSA National Advisory Council at its next meeting, and any corrections or notations will be incorporated in the minutes of that meeting.

Attachments:

Tab A – Roster of Members

Tab B – Attendees