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Substance Abuse and Mental Health Services Administration

Joint Meeting
of the
SAMHSA National Advisory Council (NAC),
Center for Mental Health Services (CMHS) NAC,
Center for Substance Abuse Prevention (CSAP) NAC,
Center for Substance Abuse Treatment (CSAT) NAC,
SAMHSA Advisory Committee for Women's Services,
and
SAMHSA Tribal Technical Advisory Committee (STTAC)

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PROCEEDINGS

Agenda Item: Welcome, Introductions, and Administrator's Remarks

MS. GERETTA WOOD: Andrew, if we could open the call now, I would appreciate it. This is Geretta.

OPERATOR: Thank you. Just a moment. You are now rejoining the main conference.

MS. GERETTA WOOD: Good morning, and welcome. This is Geretta Wood, committee management officer for SAMHSA.

We're pleased that so many of you could join us today. I'd like to remind you that the meeting is being recorded and webcast live. Council members, please remember to speak into the microphone so that those listening can hear. Please identify yourself each time before speaking, and please mute your telephones so that we don't receive feedback except when you're talking.

For those in the room, as a courtesy to others, please silence your electronic devices. And I'd like to also announce that the next meeting of this joint council will be held April the 9th, 2015.

I call this meeting to order, and I turn the meeting over to Administrator Pam Hyde.

MS. PAMELA S. HYDE: Thanks, Geretta.

Good morning -- or afternoon. Well, it depends on where you are. Some of you, good morning. Some of you, good afternoon. It's great to be with you. It's a little odd in this format, obviously. We don't get to see each other face-to-face, but I really appreciate all of you participating with us in this way.

I think, as you know, a lot of us -- or we have been trying, SAMHSA has been trying to experiment with different ways of doing our advisory council meetings in --

[Audio disturbance.]

MS. PAMELA S. HYDE: Sorry, everyone. We're having a little technological difficulty. So that's what I said. We are experimenting with how to do this virtually, and obviously, we're learning.

One of the things we did this time, with your input, is when we do virtual or by phone meetings, we're not going to have them quite as long. Many of you told us that that was just unacceptable to have to sit on a phone or in front of a computer for that long. So this one is just from 1:00 p.m. to 3:30 p.m. today. So really do appreciate -- at least east coast time. Really do appreciate your joining us.

We still have people sort of gathering, and I suspect across the country, there are some of you that are still trying to get on and make sure you're involved with us electronically. So let me just do a couple of words of, as I usually do, sort of giving you some updates. But before I do that, I want to tell you who's in the room here with me.

So we're going to go around the room and let people on the phone know. And Wes, how about I start with you, if you can just let them know who's in the room?

DR. H. WESTLEY CLARK: Certainly. Wes Clark, the Director of the Center for Substance Abuse Treatment, and I'm joined by my new Deputy, Kimberly Jeffries Leonard, who's also in the room with us.

MS. PAMELA S. HYDE: Great. Thanks. Pete?

DR. PETER J. DELANY: Pete Delany, Director of Center for Behavioral Health Statistics and Quality.

LCDR HOLLY BERILLA: Good afternoon. This is Lieutenant Commander Holly Berilla. I am going to be serving as CMO once Geretta Wood retires.

MS. PAMELA S. HYDE: You heard from Geretta, and this voice you're hearing right now is Pam Hyde.

MASTER SGT. STEPHANIE WEAVER: This is Stephanie Weaver. I am the public health analyst here for military affairs at SAMHSA.

MR. PAOLO DEL VECCHIO: Hello, everyone. I'm Paolo del Vecchio, the Director of the Center for Mental Health Services.

MR. RICHARD MOORE: Hi. I'm Richard Moore, the Acting Deputy in the Center for Substance Abuse Prevention, and I'm sitting in for the Director, Fran Harding.

DR. ANNE HERRON: Hi. This is Anne Herron. I'm the Director of the Division of Regional and National Policy Liaison in SAMHSA.

MS. MARY FLEMING: Good afternoon. This is Mary Fleming. I'm the Director of the Office of Policy, Planning, and Innovation.

MS. PAMELA S. HYDE: Okay. We have a few other people in the room, just so you know, that are helping us with the electronics here. So, and they are around helping us.

We also have a couple other staff in the back of the room, and especially I want to acknowledge Nevine because she is here I think listening in for Kana a little bit. Kana will be on the phone, if not now, eventually here shortly. Kana Enomoto, our Principal Deputy.

So, again, welcome, everyone. Hopefully, by now we've got most people on the line, and I'm just, as I said, going to do a few quick updates, and then we will turn to our topic for the day.

And let me start by saying that you heard a reference to it. Geretta Wood, who has been -- I never remember these titles, but she's been the person helping us in staffing and working with our advisory councils, and she is retiring in September, is it? November? September. She is retiring very soon. She's sitting here beside me.

So we just want to take a minute to thank Geretta for her work over the last few years, really appreciate you keeping us all together, and she actually works with me also on the SAMHSA National Advisory Council. So thanks so much, Geretta. And we I know here at SAMHSA will have an opportunity to wish you well a little bit later.

But that's why you heard Holly Berilla saying that she was going to be joining us in this role. Holly is a Commissioned Corps member. So she's sitting here in her white uniform, looking good for the summer here. So you will be hearing more from Holly Berilla, spelled B-e-r-i-l-l-a. So if you see an email or something from her, know that it is about the advisory council's issues.

All right. So the other thing I wanted to let you know, a couple other things I want to let you know is that we are, of course, in the infamous budget period. So, oh, actually, before I go to budget, let me tell you one other thing. We have a new person start this week that I just want to acknowledge. He's not in the room at the moment because he is meeting with other folks.

But Tom Coderre, many of you know him. He has been working in and around the recovery community for years, and he is from Rhode Island. He is most recently the chief of staff of the Rhode Island Senate president's office. And before that, he was actually a senator himself. Or a State rep, a political person in Rhode Island. I forget. I apologize.

But anyway, Tom has joined us as the second political appointee here in SAMHSA. And we're extremely pleased to have his knowledge and skills not

only of recovery and substance abuse and behavioral health issues, but of the political process as well. So you'll be hearing more from him later, and I just wanted to acknowledge that he's joined us this week and will be involved in some of our Recovery Month events and other things very quickly here.

So budget. Let me tell you where we are with the budget. By the way, you may or may not have recognized that Daryl Kade did not say hello as being in the room. She may be on the phone. I'm not sure. But she's actually out sick, has been out sick for a couple of days. But Daryl and her staff -- she's head of our Office of Financial Resources -- have been working very hard on our Fiscal Year 2016 budget proposal. Believe it or not, that's the period of time we're in.

The 2015 budget, which is next year -- it starts October 1, Fiscal Year 2015 -- has been in Congress, and the Senate has -- the Senate Finance Committee has actually acted on what they would like to do, but that's far from a decision. And all the information we're getting right now is that we are likely to have a continuing resolution for the first several months of 2015.

What that means is that what's going on in '14 will sort of continue in the same vein that it has at the same funding levels is what we anticipate. Now whether that will be true for the whole year is unclear. I think probably, to be honest, what happens in the fall election may have some impact on that. But for the moment, we anticipate that when Congress comes back from their August recess on about September 9th -- 8th, 9th, they will be here only for a few days. And during that couple of week period, we anticipate them doing a continuing resolution to carry us into later in the fall, if not into the early 2015.

So more about that. So 2015 is kind of just humming there for a minute. But what that does mean is that all of the proposals that you saw that we made in the President's budget for 2015 really aren't going to move too much while we're sitting and waiting for Congress to decide what they're going to decide.

In the meantime, we are building on 2015's initiatives and putting together a budget for 2016. And while I don't have either the numbers or the specifics to share with you and nor could I, if I had them, because we're not at the point where it's public, I do want you to know that we are looking at many of the things that you are seeing in the headlines today.

So a lot of issues around opioid overdose, prescription drug abuse, heroin addiction, treatment, recovery. Those kind of issues are on the table. Issues about continuing our work on Now is the Time for especially focusing on young people, and workforce development is continuing, or at least that we anticipate it continuing. And we are also looking at some of the Native youth issues that have been emerging as the President and his First Lady visited tribal country, Indian Country and have given us some direction across Federal Government about doing some of that work.

I think if you saw the President's announcement yesterday about veterans and mental health issues, while you may not have seen the word SAMHSA there or even the word HHS there, those acronyms, know that HHS and SAMHSA have been very engaged and involved in issues addressing veterans. And you're going to hear a lot about that today. So we are also in those conversations.

So budget continues. We anticipate going and talking to OMB about our budget sometime in September-ish. And then the President -- the Secretary and President will finalize the budgets for us and for all of HHS in time for the President to propose his budget for Fiscal Year 2016, which happens usually in early February of the year before. So 2015, calendar year 2015, somewhere around late January, February is when you could anticipate the 2016 budget being released.

I should say since I was telling you sort of priorities or things that we had been looking about there, the other area we've really been looking at is this issue of adults with mental health issues, especially adults, but not exclusively adults with mental illness having crises or families having crises that are not well dealt with, and therefore, people are finding themselves in emergency rooms sitting and waiting or being boarded or other kinds of crisis issues where people are struggling to find the type of response that they want, either an inpatient bed or residential bed or some kind of comprehensive services.

We have been looking at that issue as well and are thinking about how we might think about crisis systems in the country and how they might respond better. So we are looking at that issue. And frankly, we continue to have a focus on working on how people view behavioral health issues. So we've referred to it in the past as the science of changing social norms. So we continue to look at that issue as well.

We think that SAMHSA has a role and an important responsibility to try to help the country think a little differently about behavioral health and its relationship to community health, individual health, family health, healthcare, and just community living. So you'll hear more about that and continue to hear more about it. You may, if you want, every one of you on the phone and everyone on all of our advisory committees are welcome to listen in tomorrow from 1:00 p.m. to 4:00 p.m., when our National Advisory Commission -- or Council will be talking about health reform.

We're going to be joined by Marilyn Tavenner, who is the Administrator of the Centers for Medicare and Medicaid Services, will be there to talk to us for a few minutes about how health reform implementation or the Affordable Care Act implementation is evolving. And then we'll be able to take some questions, and then we're going to spend a little time tomorrow in that format talking with Chris Carroll, who's our new lead for health financing and healthcare and health

systems integration, and some other SAMHSA staff, who will be talking with you about what we're working on and getting some input from you about how you think we can go forward on some of those key issues.

So I understand that our Principal Deputy has joined, Kana Enomoto. So, Kana, welcome. And before I -- I'm going to give Kana just a minute to say anything if she wants to in just a second.

Let me just say one more thing that's coming up, a couple more things coming up that you should be aware of. September is a big month for us in SAMHSA because it is Recovery Month. So we do work all year long getting ready for this month to celebrate people who are in recovery and to celebrate recovery as a process and a construct and to support services and treatment and other kinds of things that we do to help those with addiction or mental illness get to recovery in a pathway that works for them.

So you will see more about that. There are events all over the country that we participate in or support. The most important one perhaps being here in D.C. on September 4th at the Press Club. We will be releasing, as we do every year, the 2013 data from our National Survey on Drug Use and Health that tells us about where we are in the country with things like prescription drug use, marijuana use, heroin use, tranquilizer use, you name it. And also some mental health data that comes from that survey as well.

So CBHSQ does great work on that, and we release it every September during Recovery Month. So that's coming. So watch for that. We anticipate having the National Barometer and the State barometers that bring that data together with other data somewhere in late December, early January or first of the year. So watch for that as well.

All right. There's lots more I could say, but I'm going to stop for just a second and let Kana, see if she wants to jump in. And then anybody else around the table here who has anything to update our advisers on, you can let me know, and we'll do that. And then we'll get into our topic area for the day.

So, Kana, if you're on the line, is there anything you would like to update people on?

MS. KANA ENOMOTO: [on telephone] Yes. Hi. Thanks, Pam. I'm sorry. I was on the line earlier, but they had me on mute.

I just -- I wanted to thank everyone for joining us today and to let you know that your SAMHSA staff has been hard at work, but we also have taken your advice to heart. I think last time we had a meeting of this group, they did mention that SAMHSA needed to continue to take a look at its own structures and how it is operating to sort of relieve some of the overburden that folks were sensing.

And we have, as a management team and as a whole agency, been looking at some of our operations, opportunities for streamlining, opportunities for sort of doing more with the same, doing the same with less, possibly in some places where can we do less with less. So that SAMHSA can really tackle this greater mission of advancing behavioral health for the Nation.

So we have been working across our managers across the centers and offices and trying to engage vertically as well to find pathways forward on that, looking at economies around how we manage our conferences and meetings. How do we do our HR? How can we do our evaluations? How are we doing site visits? Et cetera, et cetera. So we thank you for that advice. We've taken it to heart.

And also we'll let people know to be looking out as in the coming weeks, you're going to see the announcement of many of our grants, which are, of course, the product of work from the field as well as work from the agency and support from the administration and Congress. Our funding announcements are beginning to roll out.

We just had our CMHS NAC yesterday. The other centers are also meeting, and so the grant announcements will be coming out over the next few weeks, including ones we're very excited about, which is part of the President's Now is the Time initiative.

So that's it for me. Thank you.

MS. PAMELA S. HYDE: Okay, Kana, thank you. Appreciate it.

So I've been asked by a couple of people if we're going to do introductions. We're not going to do that today on the phone. There's too many people. And it would get a little squirrelly to do. What we're going to do is as we open up for discussion, we're going to ask you to identify yourself when you make a comment or want to ask a question. That's our advisory council members.

So right at the moment, we have about 50-ish of our advisory council members, and that's pretty good out of about 70, I think we have, are on the phone with us. So most of you are here. That's terrific.

And then we have another 45 or so people listening. So that's great. So remember, when we get to the discussion period, we're going to ask you to identify yourself as you comment. So we appreciate that.

And also we have -- let's just say a word now about public comment. Public comment is scheduled at 3:00 p.m. We need you to tell us if you want to do public comment. We have a couple people who have signed up already. And know that if you have a question, we've already gotten a couple of emails with

some questions, we will take those questions as a part of the record, but we will not try to answer them here. We will either get someone to get back to you or something.

Sometimes these questions that we get in this context are in a context that you have that we really need to understand why you're asking or what the point of the question is so we can help you get an answer better. So if you have questions, you're welcome to send them in. This is to the public. You are welcome to send them in, but we will take them -- make them part of the record, but we'll take them offline to answer those questions for you.

Okay. So I think that's all I have to say. Are there folks around the table that think there are other things, big things we ought to announce that are coming up or that you have -- are working on? Wes, do you want to say just a word about where we are with 42 CFR Part 2?

DR. H. WESTLEY CLARK: Can you hear me?

MS. PAMELA S. HYDE: Yes.

DR. H. WESTLEY CLARK: Well, we are in the process of synthesizing. We've actually synthesized the public comments, and we're pulling those things together and attempting to develop the next phase of the strategy of addressing the issue. We're vetting it within the department so that we have a better understanding of what our options are.

So looking at how to modernize 42 CFR Part 2, given the concerns raised by a wide variety of entities. We want to make sure that we modernize the 42 CFR Part 2, at the same time, protect people's privacy to the extent that it's possible.

MS. PAMELA S. HYDE: Thanks, Wes.

And I hope -- I guess I should have said 42 CFR Part 2, for those of you who don't know, is a regulation that has to do with consent about drug and alcohol treatment data that goes even beyond HIPAA. So we've been sort of looking at it in the context. It's an old reg and an old law at this point. So in the context of electronic health records, we have been looking at it. So that's what Wes was referring to.

Pete, is there anything you want to update the group on? Nothing? You're not working on anything? Oh, he says he's not working on anything. I know better than that. He's working on tons of things, but nothing he's going to share today.

Paolo?

MR. PAOLO DEL VECCHIO: This is Paolo del Vecchio. And just to share

SAMHSA's work in conjunction with our other Federal partners at CMS and the ASPE at the department around certified clinical community behavioral health clinics. This is a 7-year demonstration program, demonstration of what was known as the Excellence in Mental Healthcare Act.

Part of this effort will be to develop criteria to certify community behavioral health providers that would then be eligible for enhanced Medicaid dollars. Stay tuned for a public input session on the criteria. These clinics will meet sometime this fall, and we'll make sure all of the council members are aware of that.

MS. PAMELA S. HYDE: Great. Thanks, Paolo.

Anne, can I put you on the spot here about block grant application, and then I'll come back to Richard.

DR. ANNE HERRON: Sure. We are working on the block grant application now, looking to update some of the categories in the applications so that it will be relevant and useful for States, come '16, '17. And hopefully, we'll have it available to discuss with the States and with their commissioners within the next month.

MS. PAMELA S. HYDE: Great. Thank you. That process will take a little while yet. It has to go through OMB, and it has to go through public comment two times. So it will take a little bit yet. But watch for it coming out in public comment. So you'll be able to see the direction we're going with that.

Richard, do you have anything from CSAP, the prevention center, that you want to talk about?

MR. RICHARD MOORE: No, I think you covered the most important aspects. You talked about the opiate activity that we're involved in, prescription drugs. I don't think you mentioned the fact that we're working with the FDA around e-cigarettes and nicotine delivery products. And so, that's the only other thing that I might mention.

One of the things that we're going to do is we're going to be working with the FDA to ensure that we are consistent with what HHS is doing around e-cigarettes and other opiate delivery and nicotine delivery products. We are going to take a look at how we may make some adjustments on our side, our program, to ensure that States are looking at it and taking into consideration e-cigarettes and other nicotine delivery products to be consistent to make sure that youth are protected from these products.

MS. PAMELA S. HYDE: Great. Thanks, Richard.

So, again, we sometimes assume everybody knows Synar is the program that

requires that retailers not sell tobacco products to minors. And we enforce that by tracking it here. And if States don't comply, they are subject to withholding of significant portions of their substance abuse block grant.

So they have been very compliant. The States have done a great job about this over the last decade, I think. But with the emergence of e-cigarettes, it's creating a new challenge, and we're trying to sort through that.

Okay. Chris, Mary, anything you want to update on?

MS. MARY FLEMING: Did you mention OTAP?

MS. PAMELA S. HYDE: Go ahead.

MS. MARY FLEMING: Well, in OPPI, we're working to pull together the new Office of Tribal Affairs and Policy that was created about 2 weeks ago, pulling together key tribal responsibilities within OPPI into a -- a single office that will coordinate activities across the agency. Mirtha Beadle is the Director and will be bringing in our several staff from CSAP as a part of that.

MS. PAMELA S. HYDE: Great. Thanks, Mary.

I forgot. I apologize. We talked about it yesterday with the Tribal Technical Advisory Committee. So it didn't -- it slipped my mind today. So thank you.

And we're really excited about that office. It has to do with what I mentioned earlier, the work we're doing with the White House and IHS and others around Native youth, so among other things, many other things. It also is going to incorporate the Office of Indian Alcohol and Substance Abuse that we do as part of TLOA, or the Tribal Law and Order Act. So that's great.

Okay. Chris, did you want to add anything?

MR. CHRISTOPHER D. CARROLL: Just as a highlight, we continue to focus on eligibility and enrollment issues. We are in the last stages of developing an LGBT toolkit, enrollment toolkit. So we're excited about that, given the new Gallup survey that came out today demonstrating or showing the uninsured rates for LGBT populations.

And we continue to partner with CMS, specifically around their Coverage to Care initiative on reaching out and creating specific outreach and engagement materials for behavioral health populations.

MS. PAMELA S. HYDE: Okay, great. And I just, again, want to underscore if you want to hear bunches more about what we're doing in that area, please join in tomorrow and listen in to our National Advisory Council, where we'll be talking

about a lot of that for some time. So that's good.

Agenda Item: Military Members and Their Families, Returning Home

MS. PAMELA S. HYDE: All right. So one of the areas that I think everybody knows that we have spent a considerable amount of time on over the last 5 years is military families and veterans and their mental health issues. You all asked, as I recall, at the last meeting to have a little bit more input or a little more conversation about that. So what we want to do here is for the next 15 minutes or so, Kathryn Power, who leads our strategic initiative on military families, and Stephanie Weaver, whose voice you heard, the military affairs specialist, both of whom who have just done an incredibly intense and admirable job leading us through this issue -- I get very personally involved in this one for lots of reasons, including the fact that SAMHSA leads for HHS on the interagency task force implementing the executive order that the President mentioned yesterday.

So I think you know the President mentioned lots of things yesterday in a speech to the American Legion, 19 new executive actions, some of which we're involved in. And also a new law was just passed recently about veterans and mental health and larger healthcare issues that we definitely are involved in.

So, with that, I'm going to turn it over to Kathryn and Stephanie. They will talk for -- tell you a little bit in about 15 minutes or so, and then we're going to have a panel. And I think, Kathryn, you and Stephanie are managing the panel, right?

MS. A. KATHRYN POWER: [on telephone] Yes, that's correct.

MS. PAMELA S. HYDE: So they'll introduce the panel when they get to that, and then we're going to make sure we end with enough time for everybody else, the other advisers to weigh in, ask questions, make comments, give us advice, et cetera. So, with that, Kathryn, Stephanie, whoever is going to start.

MS. A. KATHRYN POWER: Thank you very much, Pam. It's a delight to be here with all the members of the National Advisory Council.

And I'm Kathryn Power, and I'm sitting in my regional administrator office in Boston. And thank you for looking to this issue as a very important issue. We do have a PowerPoint slide. Stephanie and Geretta, I'm not sure who's going to be managing those slides. Can you give me some guidance on that?

MASTER SGT. STEPHANIE WEAVER: Yeah, Kathryn, this is Stephanie. I will try to keep up with you. But if I miss your timing, please let me know, and I'll advance or rewind the slides.

MS. A. KATHRYN POWER: Okay. So I do not see any of the slides up yet except for the name of the slide for the advisory council.

MASTER SGT. STEPHANIE WEAVER: We're checking on that.

MS. A. KATHRYN POWER: Okay. So it's not on the screen. Let me just put it that way.

Okay. I'm going to go ahead and start, and hopefully, the slides will follow. This is an update on the military families strategic initiative, which we call the MFSI. And this is an important point in time in terms of looking at the MFSI because we are considering all of the aspects of what has gone on prior to this date, and we are moving -- as SAMHSA is moving to establish new or renewed SIs, we are going to be moving this population to what is known as a prioritized population across SAMHSA.

One of the things that I always like to start off with is talking about why this population is important, and I usually use the quote from former Chairman of the Joint Chiefs of Staff, Admiral Mike Mullen, who said, "I fear they do not know us. I fear they do not comprehend the full weight of the burden we carry or the price we pay when we return from battle. This is important because a people uninformed about what they are asking the military to endure is a people inevitably unable to fully grasp the scope of the responsibilities our Constitution levies upon them."

And I think it's important, as we retrospectively look at the military family SI and the background and we look at what we have been able to accomplish over the last several years, I think it's important to keep in mind that we are responsible for making sure that we collectively cross that military-civilian divide. If we deeply care about the behavioral health needs of this population, how, in fact, and what can we do? And we're going to get into some of those discussions with our illustrious guest panelists at the end of my presentation and then, hopefully, have some discussion with the larger council members.

Stephanie, let me stop there and say are the slides up?

MASTER SGT. STEPHANIE WEAVER: Yes, ma'am. The delay is in the actual presentation. But everything is synched. So feel free to go through the slides as you are, and I will keep up with you.

MS. A. KATHRYN POWER: Okay. So I am now on the MFSI overview slide.

MASTER SGT. STEPHANIE WEAVER: I'm there, ma'am.

MS. A. KATHRYN POWER: Are you there?

MASTER SGT. STEPHANIE WEAVER: Yes, ma'am.

MS. A. KATHRYN POWER: Okay. Great. So we have some background on the MFSI. The strategic initiative had its roots starting in 2005 when we had some of the grantee and provider agencies bringing to our attention the fact that they noticed an increase of the military and veteran populations. We heard this from both CMHS grantees and CSAT grantees who were watching this population grow either coming into our grantee agencies saying they themselves were having difficulty or they were having difficulties understanding how to treat people who were in their families.

So from 2005 on, we participated in DoD's Mental Health Task Force, one of the first task forces that was created. We developed a voluntary internal workgroup to establish goals and activities. We started to look at how we were going to create partnerships in terms of at SAMHSA and across HHS and tried to seek out people at DoD and VA and the heads of the military component commands to be able to have a conversation with them.

And then Administrator Hyde officially designated this as a SAMHSA priority when she came onboard with the other eight strategic priorities. And our goals under this MFSI were to make sure that we were focused on improving families' access to community-based behavioral healthcare, and that meant it could be accessed through any number of agencies -- through SAMHSA, through TRICARE, through DoD, and through Veterans Health Administration.

We wanted to make sure we were improving the quality of behavioral health prevention and treatment and recovery support services by helping individuals who generally are in the civilian community understand what it means to be in a military culture and what the military experience means.

We wanted to make sure that we would promote the behavioral health of military families in support of VA and DoD with the programs and sharing our evidence-based practices at SAMHSA so that we can make sure that we were focusing on the readiness issue, coupled with the resiliency issue so that we could, of course, prevent suicide and increase the emotional health of these families.

And we wanted to be sure that we focused on working with our other partners to make sure that there was a behavioral health service system through coordination of policies and resources.

Next slide.

So what did we do? So under the military families strategic initiative, here are some of our highlighted accomplishments. The first is that we have established a military service members, veterans, and families technical assistance center.

Through their efforts and through the support working with them and through the guidance provided by staff like Stephanie Weaver and Eileen Zeller and multiple people across SAMHSA, who work very closely with the TA center, we were able to host 7 policy academies with participation from 46 States and 4 territories and the District of Columbia.

For those of you on the call who have never participated in a policy academy, this is a very intensive 3-day effort to help State teams develop very sophisticated strategic plans so that they could figure out literally how they were going to serve this population as they became more acquainted with that population. Because, frankly, the civilian community for a long period of time believed that DoD and VA were going to take care of all these people and should take care of all these people, and there was no responsibility necessarily vested in a civilian community to do this.

And so, our policy academies really helped cross that bridge and say not only do the military components and assets in a State and their National Guard and their Reserve components need to pay attention to this population, but, oh, by the way, so do the State behavioral health leaders, the State Medicaid leaders, criminal justice components, and Departments of Veterans Affairs, et cetera.

We've also hosted implementation academies, which are more in-depth, focused academies on three particular areas -- military and veteran families, justice-involved service members and veterans, and we are about ready to host the third implementation academy later in September on suicide prevention. Those topics were chosen basically from the States themselves and the State policy academy members saying that they wanted to make sure that they focused on additional activities that they could do beyond what they had put in their strategic plans.

We created a TRICARE credentialing technical assistance packet. We created a National Guard behavioral health services locator to help National Guard components find community-based substance abuse and mental health services, and those are available online.

We started to include, probably back in 2009, the language in what were the applicable request for assistance, RFAs, to focus in appropriately on this population. So if an RFA was coming out and we knew that there was an opportunity to reach this population, we made sure that the language in the RFAs reflected that, and we are going to continue to do that over time as we deem appropriate.

We also had a very extensive interagency agreement with HRSA, the Health Resources and Services Administration, who are responsible for cultivating a healthcare workforce. And in that interagency agreement, we shared some resources with them to help train their health workers in military cultural competence, and they did this through their regional allied health education

centers and then reached into community health professionals to make sure that they understood the tenets of military culture and how to approach engaging a military veteran population in community agencies.

We also, as Pam has indicated, moved directly into working with many of the White House initiatives. Many from the White House itself, many from President Obama's and Mrs. Obama's and the initiatives that they looked at, and they started to do that in a process that was a presidential study directive, which eventually merged into an interagency policy council, and eventually, that became the President's report on Strengthening Our Military Families.

And SAMHSA was very much involved in that, and we co-chaired the psychological workgroup. There were four workgroups under that Strengthening Military Families. And many of those issues that were raised in that original report are, in fact, the activities that you see forthcoming or those were germ ideas that were forthcoming and that the President continues to expound and expand as his commitment to this population continues.

And then, of course, Pam sits as the co-chair of the Interagency Task Force on Veteran and Military Families. And this Executive Order 13625 is still very much in play and still very much a driver for much of the activity across DoD, VA, and HHS.

On the next page, our accomplishments continue. We worked with the National Guard Chaplains Bureau in five States to establish Partners of Care programs with faith communities. We worked with HRSA and the national council and the VA to identify community-based behavioral health providers for the executive order pilot projects. And I'm sure our guest from the VA, Dr. Tenhula, today will talk about that.

We've distributed multiple publications that were useful and relevant at the time. Some of them still very relevant. But we worked with PBS and the Defense Center of Excellence to create a publication, Veterans on the Road Home. And we, in fact, have looked at making sure that our data is reflective of the importance of this population.

So Admiral Delany has been a great partner in helping us figure out working with OMB what are some appropriate military demographic and trauma measures? We worked for over several years to obtain OMB clearance, and we've incorporated some of those measures into the GPRA survey, and now, of course, those measures will move to the common data platform under Pete's leadership.

And finally, SAMHSA represents HHS not only across the executive order interagency task force, but we also represent HHS on what is an OMB initiative for what is a cross-agency priority effort. It's called a CAP-G effort. And this is a

way in which OMB looks at continuously tracking and monitoring cross-agency collaborations to make sure that veterans mental health is improving. And that process is really projected to go through 2018.

So we have a host of activities going on. I think that we have clearly made a big difference in terms of HHS and SAMHSA's attention to this population. I think we have percolated an enormous amount of attention at the State level. We have experimented with looking at different strategies and activities, which, by the way, as you can imagine, vary greatly by States depending on the number of active duty resources they have, the size of their National Guard components, the size of their Reserve components, and where they might be located. And in fact, where people who come back from the war and are demobilized then go back in to live in civilian communities, many of which are separate and very far from either military component commands or even from VA services.

So on the next slide, what we are doing is placing ourselves in a position to say as this strategic initiative moves forward, what is still in play? Well, we certainly have our partnerships still in progress. We have memorandas of agreement with the Defense Center of Excellence in which we will share best practices. We have a memorandum of agreement with the National Guard Bureau. Succeeding former Master Sergeant Stephanie Weaver is Master Sergeant Roger Brawn, who becomes our new National Guard liaison.

And we have an MOU with VA in which we share guidelines and which, of course, we share a shared responsibility for the Veterans Crisis Line, 1-800-273-TALK. And we also have ongoing collaborations and partnerships and conversations and individuals across SAMHSA who are our liaisons with the White House's Joining Forces, with the Yellow Ribbon campaign, with the White House's Joining Community Forces, and with the Alliance of Professional Associations.

So there's a couple of goals that we are still working on, and that is we want to continue to try to influence TRICARE and look at their mental health and substance abuse benefit. And we want to look at some different strategies for how we might push out some of our evidence-based practices into very large, closed bureaucratic healthcare systems like DoD and VA.

So, for us, the way ahead is that we're going to reassure ourselves and our partners that this population is fully embedded across all SAMHSA's policies, programs, and initiatives. We're going to ensure that the ongoing interagency task force work and across agency work will, in fact, focus on the issues of access and barriers in research and also our continuing metrics work. We're going to be working with the National Guard Bureau on domestic operations plans that are focused on behavioral health issues, and we're going to engage with VA and DoD and the National Guard Bureau to look at opportunities for us to continue to support our technical assistance center.

So we have a tremendous amount of, I think, work that we've accomplished, and I always say despite the fact that we did not have a whole lot of authority or a whole lot of appropriations, we were able, I think, to move this in a very positive way. And I think the next slide is my set of questions for the way ahead for consideration not only for our guest panelists, but also for other members of the advisory councils.

What are we going to do to sustain leadership and visibility around behavioral health needs of population? Are there things we should be thinking about in terms of policy and program and legislation?

How are we going to embrace and follow on these multiple initiatives in the context of the fact that we have ongoing interagency task force work and ongoing cross-agency priority group work? How do we invest in our partnerships when we have pretty limited staff and resources?

And how are we going to move other groups to help sustain our efforts? What are we going to do to make sure that the RFAs continuously are populated with this population and that our State policy academy teams don't lose faith or lose sight? After all, they've been -- many of them have been going on since 2006.

Agenda Item: Discussion and Questions

MS. A. KATHRYN POWER: So our way ahead is really to hear from our very influential guest panelists who are going to help us think through their particular personal and professional observations about the importance of this population, and I'm going to stop there and introduce the members of our guest panelists.

The first is Christopher Wilkins, who is a SAMHSA NAC member. Chris, are you there?

MR. CHRISTOPHER R. WILKINS: [on telephone] I am, Kathryn, yes.

MS. A. KATHRYN POWER: Great. We have Mary Ann Tulafono. Mary Ann, are you there?

MS. MARY ANN TULAFONO: [on telephone] Yes, I am, Kathryn. Good morning.

MS. A. KATHRYN POWER: That's great. Mary Ann is a part of the SAMHSA NAC.

We have Dr. Wendy Tenhula, who is the National Director for DoD/VA Integrated

Mental Healthcare. Dr. Tenhula?

DR. WENDY TENHULA: [on telephone] I'm here. Thank you.

MS. A. KATHRYN POWER: Great. And also, Rex Lee Jim, the vice president of the Navajo Nation? Is Rex there?

MS. PAMELA S. HYDE: Kathryn, he was unable to join us.

MS. A. KATHRYN POWER: Okay, great. I'm sorry. Was there somebody there? Okay.

So looking at the questions for the way ahead and thinking about what I very briefly covered in terms of the evolution and our history and what our accomplishments have been, we've asked our panelists to really think about those questions, to give us some background about who they are and why they care about this population, and suggestions they have for us to move forward and to think about how we might craft this priority population.

So, Christopher, I'm going to turn it to you first.

MR. CHRISTOPHER R. WILKINS: Thank you, Kathryn. And thank you, Administrator Hyde and Kana and the rest of the staff, for structuring this conversation.

MS. PAMELA S. HYDE: Chris, can you get a little closer to your microphone?

MR. CHRISTOPHER R. WILKINS: Okay. I'm actually on the handset. Is that better?

MS. PAMELA S. HYDE: Yeah, just get it -- keep it close. Thank you.

MR. CHRISTOPHER R. WILKINS: Yes. Good afternoon, everyone. It's a pleasure to be able to speak with you this afternoon about this topic.

I began working to integrate community-based addiction services into the VA hospital structure and network structure in Network 2, which covers all of upstate New York and part of northern Pennsylvania in the VA, and I began that journey in 2002. My purpose at that time was to fill some infrastructure gaps in the areas of inpatient medically supervised withdrawal, detox service, outpatient access to medication-assisted treatment for addiction conditions, outpatient access to mobile technologies to support recovery, and access to transitional housing.

And all of that work that began in 2002 manifested in the creation of Loyola Recovery Foundation, the agency that got put together to deliver those services. And the initial mission of that, and it's the mission that continues today, was to

deliver those -- those infrastructure fill services in a way where veterans were governing the service and now, I'm happy to say, in a way where veterans are managing the service at the executive level, at the middle manager level, and in the workforce.

So that was the mission and the purpose of Loyola, and that's been the work that's happened over the last 12 years, and I think that's what brings me to the call today.

I think that it is a table that through SAMHSA's work and VA's work and DoD's work and the administration's work that has been robustly set. But it's a full banquet. There's a lot on the table, and there's a lot to look at. There's a lot to understand. There's a lot to taste, and there's a lot to digest.

So I want to just make some opening comments about what the experience of trying to fit in a VA system as an addiction specialty provider has been like, and I wanted to sort of amplify 10 points that I think everybody who's going to try to partner with VA needs to know. There is this tremendous, tremendous scope of opportunity now to fill in infrastructure and to help out. And there's no shortage of will to help out or, in the other metaphor, to enter the banquet hall and be part of the party so we're sitting at the table.

So 10 things I'd like you to think about, and then I just want to make a final couple of comments that go directly to the heart of Kathryn's questions. So if you're thinking about getting together with the VA system, I think you've got to first ask, and the first point, is there a common understanding of need between the VA health system, both at the network level and the local medical center level, and you as a partner?

And then a second layer of that question, is there a common understanding of need between the community, the VA, and you as the community partner? And then a third level, is there a common understanding between the State, the community, the VA, and you as the community partner? And then finally, and probably most importantly, the last level, is there a common understanding between the State, the community, the VA, you as the community partner, and the veteran or veterans groups who may want to inform the conversation?

Why do I separate those things out? Why don't I just put it all in one analysis? Because as you add each layer or add in each participant, your understanding will change. And the commonality of the perspective that develops is going to be very dynamic, and you have to really discern hard how to find the truth of what people think they really need.

Second point. What standards are you going to operate under if you're operating in that system? What protocols are you going to use administratively and clinically? How are you going to staff things? How are you going to align

with the VA/DoD standards in any one of the areas that you're trying to touch?

Third point. What accreditation are you going to be responsible for? How are you going to align your accreditation as an organization with theirs? And make those accreditation standards not only compliance matters, but living matters that actually improve the quality of care.

Fourth point. What do you think about cost of what you do? You've got to be aware of it. You've got to understand the cost model. Are you risk sharing? Are you acting as a per diem provider? Are you entering into some outcome or accountability-based cost arrangement? Is your cost of delivering the outcome that everybody is contracting for in fact the most efficient cost out there?

But you've got to have a statement or a case statement on that matter and understand it, and VA has got to understand it.

Fifth point. How are you going to share data? How are you going to communicate? That is the coin of the realm in healthcare today. How are you going to be patient-facing in terms of your communication? How are you going to be institutionally facing with the VA and the DoD folks, and how are you going to get that stuff done?

Sixth point. What outcomes and measures and reporting structures are you going to use to inform the entire process?

Seventh point. What quality and environment of care standards are you going to meet?

Eighth point. Is the veteran you're serving -- and I love this one, guys -- completely, totally, and utterly satisfied with not only what you do, but with how you coordinate what you do with the care providers that they have in the VA? Many of the typical Loyola patients served may be served by the Loyola mPOWER Program that offers outpatient technology and access to medication-assisted treatment for addiction. But they are also enrolled in a PACT team for primary care, maybe an outpatient substance abuse or mental health program.

Maybe they've got a care manager that's attending to some of their needs in other areas, and all of that has to be knitted together so that people are working in one direction and that that direction is the one that the veteran has self-determined that he or she wants.

Ninth point. Remember, as a community provider in a big national health system, your job is to provide flexible infrastructure. In other words, don't enter the conversation with the expectation that you're going to start something and it's going to go on for a long, long time. You may be acting as an expert pro temp player or as a piece of infrastructure that's meeting a rising need that once it's

quelled that you may have to take down or greatly diminish what you do.

Understand that you're playing that role and that you have to be flexible in terms of your planning about how to get that done.

Tenth point. How do you get into the legal relationship? Well, there are a couple of pathways. You can go through the standard procurement process. Most days on Federal BizOpps, you'll see solicitations for things very, very close to what we do as community providers. You can enroll with HealthNet or with TriWest to be part of the VA out-of-network care care management network. You can enroll as a TRICARE provider.

Or you can simply as a grassroots matter, like we did at Loyola, initiate a grassroots effort to meet a community need and then convince central office and contracting and everybody else that it's the right thing to do. You've got to distinguish whether you're going to be a competitive player or if you want to try to distinguish yourself as a sole-source player.

And all of those things taken together, I think, bring me back to Kathryn's, I think, well-determined and well-apprehended questions. What do we need by program? Well, if there's an infrastructure need to take care of all those folks that Admiral Mullen directed our attention to, then we've got to have program that will inform people not only to have the will or to know the opportunity, but to get ready. And so, program ought to be focused on how you really understand your task and how you can access the right tools to prepare yourself to align with big health systems.

In terms of policy, I think the policy movements, both by regulation and by -- and by legislation, have been well intended, but a bit uneven. And so, understanding everything we've done maybe in the last 5 to 7 years and making sure that we haven't created any intentional misalignments there would be good. And correcting those misalignments and creating some equilibrium would sort of benefit the overall process.

I'm going to stop there. I hope that was helpful, and let me turn it over to our next panelist. Kathryn?

MS. A. KATHRYN POWER: Oh, thanks, Christopher. And I'm going to give Dr. Tenhula a couple seconds to think about it because I'm going to go to her next, since you've raised some of the very vibrant issues with the VA and just quickly ask you a question about if you were going to give people the elevator speech about if they're interested in getting into serving this population, from your perspective, what is the best way to think about expanding their capacity?

I remember when we had a prior conversation you talked about capacity, tenacity, and veracity, which I was really taken with. And so, how would you help

people think through what they would have to do about capacity? And is that strictly a workforce issue, or is that another issue?

MR. CHRISTOPHER R. WILKINS: Yeah, thank you. The reference was I said to Kathryn you need three things to work with the VA -- capacity, tenacity, and veracity. I'll get back to capacity to answer the question. But tenacity is, you know, understand that you've got to be able to spend the time and the money and the organizational will to work through a big bureaucracy that's got a lot of regulations.

And most of them, in my experience, are there for a reason. And then veracity is about the level and quality of the relationship. You can't let the patient or the institution down. You've got to be able to work very faithfully and very transparently in everything you do.

But let's talk about capacity. Kathryn, I think it goes beyond workforce. I think you've got to be ready, both intellectually and with capital resources and with support of your stakeholders, your board, your community stakeholders, and any other resources that you have, to deliver the administrative systems, the electronic health systems, the mobile health systems, the quality assurance systems, all of those things, the human resource system, so that you can properly credential your folks.

You'll find that when you offer personnel to work alongside our friends and partners in the VA that many of those folks are going to have to go through a second credentialing process.

MS. A. KATHRYN POWER: Right.

MR. CHRISTOPHER R. WILKINS: And that that's going to -- that's going to take a good bit of time and a good preparation on your part, just for one example. And so, those administrative resources need to be onboard. Workforce has to be credentialed properly and trained properly beyond the credentialing to be able to align their work and do their work in a way that the VA would want it done.

And then last, but not least, your ability to communicate. I can't stress this enough. To sort of very, very, very precisely set up with your healthcare partners in the VA how you're going to talk about individual cases, what's going to happen when there's an incident with an individual case, and what's going to happen when an individual case is highly unsatisfied. How you're going to resolve those difficulties is all very key.

MS. A. KATHRYN POWER: Okay. Thanks, Christopher. I appreciate it.

Dr. Wendy Tenhula, I'm going to turn to you since Christopher has raised so many interesting issues about the relationships, and I know the VA is focused,

focused, focused on not only their own inherent and internal issues, but also on partnerships and developing community relations.

So, Wendy, you want to take it away?

DR. WENDY TENHULA: Sure. Thank you so much. Can you hear me okay?

MS. A. KATHRYN POWER: Yep, it's fine.

DR. WENDY TENHULA: Okay. Good. Thank you so much, Kathryn and Administrator Hyde, and I want to shout out to Stephanie Weaver, too, who I've gotten to work closely with both Kathryn and Stephanie over the last several months on some of the interagency task force work that Kathryn and Administrator Hyde referred to, and the CAP-Goal. And we'll look forward to having HHS involvement in the new actions that were announced yesterday by the President as well.

So, and thank you for including VA in this conversation, including me, I guess, as a representative of VA. I should be clear that I am not VA. I work for VA, but most of what you'll hear me say are sort of my thoughts on and ideas. So want to be clear about that.

And I think, Christopher, you -- I love your outline, and I think all of those 10 points are so important and really help me from inside the walls of VA think about what we need to do to make those partnerships work better. And I think, Kathryn, to a point that you made a few minutes ago, within VA, I think we've done -- and I've been in the VA system for about 15 years. I'm a psychologist by training, and I've done a mix of research activities and training activities and clinical activities, as well as policy and sort of national strategy activities in more recent years. And I think that we've done a lot within VA to improve care.

I'm most familiar with, you know, what we're doing with in mental health. But making improvements in care, making -- training clinicians in evidence-based psychotherapies for the most prevalent mental health disorders, conditions that we see, things like that to really improve the care that we offer when somebody comes to VA.

I think we're starting to do a little bit better job of looking at how community organizations and community providers can help get veterans into VA care when that's appropriate and makes sense. And I think we're starting to do a lot more and what I think, you know, most of our discussion will probably be about today is increasing or responding really, excuse me, to our -- the increased awareness, both within and outside of VA of the critical role that organizations and providers and communities outside of VA play in the lives and the health and in the mental health of veterans and their families.

We know that we have limits. You know, this is born out of necessity. In a lot of ways we have limits on what VA can provide, both statutorily and otherwise, to family members, as well as not all veterans are eligible for VA care. And you know, we also know that many veterans choose not to come to VA for care.

And so, the more that we as a system can do to partner better for both to help community providers and organizations understand what VA does offer and how to help get veterans into VA care, if that's appropriate, but also help community organizations and providers understand veterans and military culture and veterans culture and veterans and their families better, then we're all going to do a better job of helping improve the lives of veterans and their families.

So that's sort of the perspective that I come at it from is that we need to do more, and I think VA is, as a system, realizing that, and you know, within mental health, but also as was pointed out, as a larger system, there's really a necessity there. There is now legislation that allows us and that opens up opportunities to do that in different ways than we've been able to do before or really have looked to do systematically before. I think there have been pockets of excellence around the country where that's been done well, but it really hasn't been across the board.

So a couple of things. Does that -- Kathryn, does that sort of start to get at what you were hoping?

MS. A. KATHRYN POWER: I think it does, and I think I probably want to just make sure that people know about the effort that you -- that the VA has made relative to the community summits and the kinds of dialogues that that's opening up. I'm actually going to a community summit tomorrow in Massachusetts and --

DR. WENDY TENHULA: Oh, great.

MS. A. KATHRYN POWER: And what is happening in those, which really is it's a wonderful kind of opportunity as VA opens its doors and windows and starts talking to these community partners. There's lots of different ways in which those relationships are developing.

DR. WENDY TENHULA: And Kathryn, that's exactly the next thing that I was going to talk about. I was going to sort of shift gears and talk about a few specific examples, including the mental health summits, if that makes sense, about ways in which I think community organizations and providers can link with VA and learn more about VA and how we can learn more about how we can serve veterans and their families better together. So I'll mention, since you brought it up, Kathryn, the mental health summits.

So, in 2013, each VA medical center was charged with hosting what was called a community mental health summit, and the idea was really to help build or sustain collaborative efforts with community organizations outside of VA, with veterans,

with their families, and with community organizations. So there were 151 summits held in 2013.

All of those generate -- each of those generated an after action report, got feedback from community organizations. We took that input to heart, and one of the outcomes of that in terms of what did people want to learn more about and what could we do to do a better job of maintaining and building those linkages? And one thing that we heard loud and clear is that events and opportunities like that needed to continue.

And so, now going forward, starting with this year and going forward annually every VA medical center will have -- will host a community mental health summit. And that will -- and so, you know, I hope that we'll do a good job of getting the word out to providers in those communities. Each facility is really designing the summit to best meet the needs as they are seen in their local community. So we're not dictating from on high what each of those should look like. We're giving some general principles and some topics that we know are critical that, again, based on the feedback from the first round of mental health summits that we know are critical to cover.

The two that we are asking each of the facilities to cover this year in their mental health summits are military culture and something related to veterans' families. Those are two areas where we know, you know, there are limitations on what we can do in terms of treatment for and working with families. And so, partnerships with community organizations and providers who can help support family members and help understand their experiences and improve their experiences is critical.

And -- and then, secondly, the military culture training is something that, you know, providers within the VA system learn quickly, hopefully, because most of the patients they're working with are veterans. But not always. So we're actually doing a push to educate VA providers as well. But we have developed jointly with DoD a military culture training course that's available online and offers free CEUs to providers, regardless of whether they're employed by VA, DoD, or none of the above. And so, we hope that that's -- that's one resource, but also by covering it in the mental health summits and addressing it.

Also as part of an outgrowth of the mental health summits from last year, what we've learned is that community providers and community organizations don't always know how to connect with VA or how to help a veteran or their family member connect with VA. And to try to help bridge that gap, each VA facility has now identified a mental health point of contact for community organizations to be that sort of center, central point of contact person, the go-to person for organizations outside the VA to make contact or to help a veteran make contact and help navigate that system.

As Christopher's comments make clear, it's a huge, complicated, bureaucratic system, and it's different, you know, across the country. In different facilities, there are differences. There are local nuances.

And so, we thought it was really important to have a local person at every facility that can be that door for community organizations and for helping also it be a two-way street, where we can help veterans or their family members who are being seen in VA make linkages to supports that are outside of VA. Again, sort of recognizing that VA cannot be, and people don't want VA to be the only resource that's available to veterans and service members.

Veterans themselves don't want that. Family members don't want that. And you know, there are things that we're very good at, and there are lots of things that we can't do or that other organizations or providers are equally or better equipped to do. So, so recognizing that.

Really that the idea of the mental health points of contact as a two-way street, but from the perspective of a community provider or community organization, it's a door or a window at least into the VA system and to help encourage those linkages that we know are so important.

MS. A. KATHRYN POWER: Great. Thanks. Wendy, I'm going to stop you there just for a couple seconds.

DR. WENDY TENHULA: Yes.

MS. A. KATHRYN POWER: And be thinking about when I come back to you a little bit about sort of the efforts that the VA is making about making sure that veterans are engaged in healthcare and some of the enrollment and engagement strategies that VA has been using to make sure that they're engaged.

But I did want to get Mary Ann Tulafono out here so that she can introduce herself to people and talk a little bit about her background and her personal and professional observations relative to this population. And then we're probably going to open it up for more of a group conversation across all of us.

Mary Ann?

MS. MARY ANN TULAFONO: Administrator Hyde and everyone there in Washington, D.C. And I've been sitting here since 4:00 this morning, and I did make the CSAP this morning, Pam. So, and it's an honor also to be able to be included in this conversation.

Last week, and Kathryn, in speaking with you and in broaching this particular subject of, you know, the military, military families, what I bring to the table here

is that my work prior to the -- I'm now heading a nonprofit organization -- as the former first lady of American Samoa and being in that position for 10 years allowed me to bring to the table a different perspective from a political, you know, perspective, if you will.

And what my particular initiatives were was with underage drinking. I have learned a lot in terms of how in this now work that I do, as you're going to hear --

[Barking in background.]

MS. MARY ANN TULAFONO: And those are the dogs. That's a welcome to Samoa. That we are -- that we are -- it allows some of us here in the territory to be able to learn and to bring back home and share with, you know, our people here in the territory which is a much-needed perspective on how to -- how that we can better the lives of our people here in the territory.

For those of you who are not familiar with American Samoa, we are basically a -- we are a U.S. territory under the United States, and we are the southern-most possession of the United States here. And we're about 2,300 miles out of, you know, from Hawaii. And because of the extremely limited economic base and of our present population in American Samoa, we're about 68,000. And yes, I know that's probably equivalent to very small communities that you all have there throughout our country.

And our -- what we do here in the territory, well, my work specifically is that in working with -- in working with our youth, and I still truly believe that again the initiative to maintain our children where they need us the most is it's paramount from where I sit because with a rich history of the territory that we have with the United States and our accomplishments and to maintaining our status as very proud Americans, that we do have our military presence. And we were -- we have a -- we do have a veterans center here, and in the last conversation, Kathryn, that we had I was not -- I wasn't certain at the time as to what specifically, what specific services that we do have here.

And I was able to do a little homework on this, and I did acquire a very, very well, good source of information, which is and I'd like to just make mention of him is [inaudible], a retired sergeant major, U.S. Marine Corps, a 30-year retiree. And he's a former local veterans affairs officer from 2010-2012. And he is also the commander of the VFW Post 3391 and also presently a board member of the Hawaii VA Medical Board.

When we talked about the issues that what is it specifically that you veterans here that you would like for the, you know, SAMHSA, the initiative that we are looking and how we can have these folks, you know, here have a voice from all the way down here in the Pacific, you know? And so, the one big issue that they had shared with me was that according to back in 2004, during the Gulf War,

and that was the first deployment of our -- of our citizens that participated in the war. And that first deployment that had left from American Samoa, the returnees came back with huge issues, mental health issues.

And for various reasons, not just the post war traumatic stress and all of that. But because for many of them, the first time leaving the territory and entering into this kind of, you know, conflict. The -- so, and when these military veterans return back, they found that at the time there was no -- there was no VA hospital here or clinic here in the territory. So everyone had to travel to Honolulu, Hawaii. And for here, as presently, there is no facility. I was told that there is no facility for the children.

The TRICARE, and I'm just going to go through this as they gave me a list. And the TRICARE here in American Samoa, I was told that they are they are classified as overseas. And the overseas TRICARE recipients are in -- are registered, I believe, or they're classified under Okinawa, Japan. And the question remains why Okinawa, Japan, when Honolulu, Hawaii, is so much closer?

And so, and again, if the services and again the privileges and where these retirees come back home. They leave the military. They come back to the territory, and because the lifestyle here in the territory is very, you know, it's very, very slow compared to the outside world, if you will. So they have such a huge transition to make from the services that they had been -- they're used to, and again now having to -- now having to, aside from going to a VA clinic that they have here in the territory, and we have specialists who come on island, and they come periodically, and they will do their visits here in the territory.

And once these at any given time that these veterans or these services are deemed that they are not -- they're not able to handle the service here, then the arrangements are made for the veterans to travel to Honolulu, Hawaii, and their appointments there are done or, you know, are complete there in the State.

The issue here that what they were talking about in terms of what the hospital here, unfortunately, our local hospital, again, it is administered or I wouldn't say administered. A huge part of the funding comes out of DOI. The TRICARE issue is prevalent from their perspective because the -- it's I'm told that the -- I'm told that in order for them to utilize the local hospital is not a -- it does not meet Federal requirements, standards.

So, again, if a veteran is has an emergency and the clinic is closed, they end up at the local hospital. And they are unable to use these funding, you know, their TRICARE because they were told that DOI funds brings in a lot of money to the hospital, and the Veterans Administration will not acknowledge that. So that, again, is an issue of itself.

That all of those and there are many other issues that they've talked about. But for me, personally, what I'd like to talk to you, you know, just to bring to the table also is that in my work -- personally, again, I have children that have served two tours in Iraq and Afghanistan. They just PCS out of Honolulu, Hawaii, and giving a shout out. They just got into on Monday, into Fort Riley in Kansas. And like many, many other of our children who are in who are in the military.

Because of our economic base is very, very limited, we encourage, as a matter of fact, past administrations, we and our present administration and our governor, we -- because the jobs are so limited and a consideration to going into postsecondary education, we only have one 2-year community college. And we have a lot of colleges that we do, there are 4-year programs, but because of the poverty levels here in the territory, it is not a high priority on -- you know, within our families.

Having said that, what we encourage our children to do is to go to the military. And why the military? We have a huge presence that out of the territory here that the children, it will allow them. It will allow them to venture out into the world, if you will. Get educated. Learn a skill. Get a -- you know, a background for them that will allow them to take care of their families back home and themselves as well. And at some point in time when they do return back to the territory, to give back.

So, again, with my work here in this nonprofit organization is what it does, what I do is that and we've been able to focus on a program that we have under the BGCAS, which is the military mission outreach. And that is because during 2004 where we -- at the time with the governors, at the time we discovered that when half of the U.S. Army Reserve, which is it's a company here on island, that when they all -- when they moved out and they were activated and they had gone to Honolulu, Hawaii, and ultimately deployed, it left probably a good 55 to 70 percent workforce hole in our workforce.

Meaning that half of the men were all gone, you know, and it left women and children back home, and it was like -- and at the same time, too, you know, so there was a huge hole in the workforce. In the government, it was very much a concern. And by the same token, you had military children who are Samoan children who live away, stationed, you know, in the mainland. They turn around and they send their children back home to grandma and grandpa, uncle and auntie, you know, and brother and sisters. And so, these children came home.

They came home with a different mentality that they were again being moved, being uprooted, and having to go back to just to the territory. And a lot of these kids, and if I can just share with you that they had no idea that in coming back to what the exposure here in the territory is nowhere near what you would get, you know, from living outside. So it was a huge challenge for these children.

And seeing that need, there was a need there to stabilize the children and give them an environment where they would be safe, we have handled over 300-plus, and we continue and it is our main focus to bring in our military children and be a part of our organization. And it's again to provide a stabilizing family environment, safe environment for them among their peers. Educationally develop and to know that, you know, that when their parents are being deployed, you know, that they're going to be cared for.

So that's pretty much from where I sit. And I'm completely different from -- I'm not speaking to any of the programs that you folks have here that Dr. Tenhula and also, Mr. Wilkins, what you spoke to earlier. But I again, what I bring to the table here is from a community organization and the work that we do, and I believe that in addressing the needs of the children and also of the spouses, it's huge. It's huge for us here because and a lot of factors that need to be put, come into play.

When the communications, we don't have the communications. Again, you know, the military folks are sitting here, the families, and everybody here. You hear the common saying, and I'm going to just throw this out there, that all Samoans are all related. Well, yeah, we are, you know, because we are one big family. And we're proud of it. And the fact remains that when one of our sons and daughters goes off to do their military duty, they all become our children as well.

So, again, I would like to -- that's what I'd like to bring to the table this morning, and I hope that it was -- it's not too far off base from what we talked about, Kathryn, and in listening to all of the initiatives and what's going on here. And again, as I did say, and I don't know if I mentioned it, in the 10 years that I've been in my previous -- wearing my previous hat was allowing me to listen to -- go through two administrations, presidencies and to listen to the former First Lady and First Lady Michelle Obama, and when she started her program Joining Forces and attending the NGA.

And then when the NGA, when the spouses all come together and we hear the First Lady's initiative, you go back and you carry these programs on within your respective States and territories. So these, again, are there is a different level of participation. There's a different level of -- but no less, any less commitment, you know, no shortage for that area from where I sit here in the territory and the work that we do here for our children.

But, and also again with our veterans, they were very excited to hear that I would be speaking, and they wanted to be a part of this this morning. "Can we listen?" But unfortunately, a lot of them don't have communications, you know, connectivity. So I hope that perhaps at some point in time, Pam, Administrator Hyde, if we could, if there is a way that we could probably get a tape of this? And I would certainly like to bring this to, you know, to our veterans here. Share

that with them, you know, the information.

And again, all of these initiatives that are going to be coming down and it looks great. It sounds wonderful, and I am very -- I feel very blessed to be a part of this astute group. And thank you very much.

MS. A. KATHRYN POWER: Thank you, Mary Ann, very much. And I'm struck by you reminding us that this is all a very personal and very family-oriented issue for many of us. Many of us have either served in the military ourselves, or we have military family members that have served or are serving now. And instead of what it used to be like when I was growing up, where you grew up on separate military active duty bases and you generally lived a pretty isolated life and you didn't have any communication with the civilian community, and all of my healthcare was taken care of in an active duty military treatment facility, those days are over.

And I think you've articulated very well the fact that this is now a civilian and a community opportunity to show that they care, to show that we value the military services, that we value the people who have offered themselves to our national defense, and that we value them even as they come home and as they face, I think, issues relative to access to behavioral healthcare.

So thank you, Mary Ann, for that, and I think that was very helpful and very, very appropriate.

What I'd like to do now is have just a period of time when the four of us have sort of an open conversation, either commenting on what we've heard each other say. I have a couple of questions that have already come in from some of the National Council members. So before I go to start of those questions, Chris, Mary Ann, Wendy, did either of you want to comment on what you heard from the other guest panelists?

MS. PAMELA S. HYDE: Kathryn, this is Pam. Let me just jump in here and say, remember, we've only got about 25 minutes left, and we need to get to the open part of the -- letting the council members ask questions.

MS. A. KATHRYN POWER: Oh, okay. Because I have some of those questions already.

MS. PAMELA S. HYDE: Yeah, but we want to make sure people have an opportunity to give us advice and comment. So if you can get to that as soon as you can, that would be great.

MS. A. KATHRYN POWER: Okay. Sure. Let me just -- let's go to that unless, Chris, Mary Ann, Wendy, do you have any comments about each other's observations?

MS. MARY ANN TULAFONO: No, everything. I'm good on my end. Thank you, Kathryn.

MS. A. KATHRYN POWER: Okay. Okay. Let me go to a couple of questions have already come in from the members, and I'm going to kind of reframe them so that I can throw them out to all of you as our expert guest panelists.

There have been several questions about culturally specific interventions or culturally specific initiatives across the veteran population, and I'm going to ask each of you to speak about that from your perspective. Are you aware of any? Are there any that are going on within your purview?

And in particular, there seems to be interest in AIAN populations, tribal populations, et cetera. Let me just start answering the question by saying that we have had some consultations between our technical assistance center and some of the State policy academy members who wanted to reach to the tribal communities who, of course, serve in very high numbers in the active duty military. So the AIAN population is really overrepresented relative to proportionality in serving our country.

And so, there is some interesting observations to be made about that. But let me go with the question to all three of you, if you have any information about culturally specific interventions, initiatives, and anything specific to AIAN or tribal communities? Okay.

DR. WENDY TENHULA: Kathryn, this is Wendy. I can jump in and say a little bit, although the real expert on this in our office is Dr. Larry Lehmann, who often does a lot of interactions with SAMHSA as well and has been very involved in the policy academies and has done a lot. He and his team have done a lot of work with the Indian Health Service, including training kind of going in both directions. Training VA clinicians about cultural aspects related to caring for Native American populations and also educating, I think, the Indian Health Service about VA and military culture and veteran culture.

And I know that in policy, VA either provides or permits for -- this specifically applies when veterans are in the hospital, either provides or permits access to traditional spiritual cultural care services to patients that request those services while they're in a VA medical facility. So that particularly applies primarily when someone is in the hospital, like I said. But I think reflects kind of an awareness on the part of our system and certainly the collaboration over the years with Indian Health Service, reflects, as you pointed out, the importance of that population.

And then, you know, there are -- so that's the specific example I guess I would cite for the moment.

MS. A. KATHRYN POWER: Okay, thank you.

And one of the questions actually is asking SAMHSA for us to think about the military population and the tribal population in similar ways, which I think is kind of interesting since we have -- we have, you know, tribes as a population of focus, and now we have military and veterans as a population of focus, for us to think at SAMHSA about how to think about those concurrently and not -- and not separately, which I thought was an interesting question.

DR. WENDY TENHULA: Well, and the first thing I think -- I think about, but maybe this is just my bias or reflects that I've been focusing too much on this military culture training course, but is the need to -- the cultural specificity of addressing the needs of someone or a family member of someone who has served in the military.

And I think just by encouraging all healthcare providers, mental health or otherwise, and particularly outside of the VA and DoD system to just ask about military status, whether the person in front of you or someone that is in their family or close to them has served in the military or is serving in the military would go a long way in helping our communities as a whole do a better job of understanding and supporting veterans and service members.

MS. A. KATHRYN POWER: Okay. Thanks.

MS. MARY ANN TULAFONO: Kathryn, if I may? I can add to that from a cultural perspective here. You know, for our Samoans, you know we are a very religious group here, and when these -- when our veterans come back home and because the -- we start off or the foundation of the families here in the territory culturally is that we start off, you know, within the church. They grow up in the church.

And so, when they go off and they come back and they are reintegrated back into the territory, the focus and there's a huge assistance that comes from our churches. Our reverends, whatever denomination that the veterans are, but we allow -- we -- again, we focus on the assisting them with, you know, just talking it out. So, again, the cultural perspective for us here in the Polynesians, here in the territory is again going back to the churches.

MS. A. KATHRYN POWER: Okay, thank you. Christopher, anything you want to add to this?

MR. CHRISTOPHER R. WILKINS: Yes. It's a terrific question. And we responded within our humble means by having one senior staff person who is a Native American combat veteran from the Vietnam era. When we talk about this, it's got levels that have to be addressed -- culture, gender, era of service,

combat versus noncombat, understanding how all of the complexity of each person's person who they were before service, person they were during service, and person they were after service have to be accounted for.

It's a bit of that -- it's a bit of that understanding these are not patients. They're people. And you're not treating a patient. You're treating a person with a family. And all of those contexts have to be very, very carefully considered.

MS. A. KATHRYN POWER: Thank you very much, Christopher.

What I'm going to do is see if, Pam, I think we want to open it to other members who might want to ask a question? Is that correct?

MS. PAMELA S. HYDE: That's correct. Yeah. So anybody who is a joint council member should have an open line. So just jump in, identify yourself, and Kathryn will work with you on comments or questions.

MS. A. KATHRYN POWER: And we're going to try to ask people to keep it as brief as possible so if there's a queue that we can get the gist of your question or comment or suggestion. And frankly, again, a question here is, you know, what's the way forward? What do you suggest that SAMHSA does in our work as we -- as we move through 2015 through 2018?

OPERATOR: Again, if you would like to ask a question, you may press *, then 1 on a touchtone phone. Again *, then 1 to ask a question.

MS. PAMELA S. HYDE: Andrew, we're not opening to the public here. We're just opening to the joint council members, and they should already have an open line.

OPERATOR: Thank you, ma'am.

MS. PAMELA S. HYDE: So this is joint council members. Anybody on the line who is one of our council members that has a comment about military families, either the work you do or questions or comments or advice for us?

MS. JUANA MAJEL-DIXON: [on telephone] This is Juana Majel-Dixon. Can you hear me?

MS. PAMELA S. HYDE: Yes.

MS. A. KATHRYN POWER: Yes.

MS. JUANA MAJEL-DIXON: Good. There is something we discovered in our MOU we signed with the Veterans Administration and Indian Health, and what we discovered is that here in where I am, in California, we've had to agree to

receive veterans in the local area once they -- the veterans said that we will honor this MOU on condition that all veterans are allowed to use the Indian Health clinic.

And that meant everybody who served and didn't matter what term or what component. If they were a veteran, they were to be seen at our Indian Health, which has put a stretch on things. It also created a great conflict in terms of the inability of the veterans willing to change their codification of prescriptions. Even though it was the same drug and the same dosage, they just had a different code and recording billing.

And so, what seemed like administrative easy to resolve, it's turned into a political football, and so what ends up happening is that the services don't get rendered to our veterans. Even though our Native brothers and sisters could access that, they're unable to unless they leave the reservation, even though we went at great strengths to change that.

Although I do commend the comments. I've enjoyed them. And I like the first shot out of the gate with the list of 10 points, which helped me to focus all of you and especially our Pacific Islander comments. They were very similar to the things that we face as tribes.

So if you put that on your radar screen as something to address in order to streamline this because I think the direction is correct. The QA I'm sure will go before TTAC on how to get the best quality assurance and quality control responses to the best data to show the impact this has had. But because of that criteria -- those two things are pretty big -- we're having a slow start out the gate to be able to utilize this new relationship with the Veterans Administration and serving our vets.

MS. A. KATHRYN POWER: Okay. Well, thank you very much. I appreciate the comment, and we will definitely look into it.

Other comments from the NAC members? Other questions, observations, suggestions for future focus on this population?

MS. PAMELA S. HYDE: It might be worth saying to advisory council members as they think about this that -- this is Pam. That we've actually done, and I should say Kathryn and CMHS and some CSAT people and others and Stephanie have done a lot of this work, frankly, without a lot of money. We haven't really had a grant program to do work on this.

We have identified a few funds to do the TA center, and we have in a couple of years gotten one-time resources to do the policy academies. And I believe one year, if I recall, Kathryn, we got money from DoD to do the policy academies. But this is really an incredible amount of work that we have done using the

resource of time -- so Kathryn's time, my time, Stephanie's time, some other folks' time -- and a little bit of money for some technical assistance and, as I said, once in a while, a one-time money here and there.

We don't have money coming up in future budgets for policy academies or anything else, although I don't know, Kathryn, if you could say how the CR might affect that one way or the other? I can't remember for sure.

MS. A. KATHRYN POWER: Yeah, I don't think the CR will help us because we really don't have the continuation money from the appropriation. We didn't have that in 2014. So we will continue to support the TA center at a minimum level in terms of the resources that support it from the block grant, but that it will be very difficult to identify any other resources even as the CR moves forward.

MS. PAMELA S. HYDE: Okay. So does that generate anything for the council members? Again, part of the reason I raise that is to say to you, as we have said many times in different ways, is that we have an incredible amount of resources in our grant programs, but we also have other ways to impact the Nation's behavioral health. And this is an example of one of the ways that we have done that.

And I don't know, Wendy, if you -- you mentioned it, and I really appreciate it. But if you have any other comments to make about how a Federal partner can help another Federal agency to try to do what you're trying to do and yet at the same time I know you mentioned that, Wendy, that not all veterans are actually eligible for VA services. So, to the extent that we are trying to help you and also you all are trying to help us, we learn tons about mental health technology and service delivery from the military and from the Veterans Administration.

So, Wendy, any comments from you about that?

DR. WENDY TENHULA: I'm trying to think. So I think that we absolutely, and I hope I'm answering your question, can continue to help each other in some sort of formal levels at the national level through the interagency task force and through the cross-agency priority goal and other efforts that happen. I think another thing we can do is identify and both of our systems can work to identify local pockets of excellence and best practices and help figure out what's working and what's not working, you know, especially what's working and how we can help promulgate those practices.

One example Kathryn alluded to earlier is as part of the executive order from two summers ago on veterans and service members mental health, VA was established -- the requirement was to establish 15 community pilots. That is relationships with community healthcare providers, mental healthcare providers in the community whereby VA would pay for veterans to receive care at those locations outside of VA, which -- and we were able to establish 24 pilots versus

the 15 that were required.

And we're currently in the process of looking at the results from those pilots, and I think and hope that we'll learn a lot, especially as we are -- we didn't realize at the time how important it would be to better understand how we could develop those partnerships in a systematic way. So I think continuing to build on the experience from those community pilots and continuing to find ways that we can help make providers within both of our -- under sort of both of our umbrellas understand each other's and have better awareness of each other's resources.

So for veterans to or their family members who don't want to come to VA or can't come to VA, what can we do to help make sure that the VA system is better aware of where we can send them and what -- and help the community be better prepared to receive them and vice versa? How can we take up a broader community perspective from within the walls of VA and learn from best practices that are happening outside of VA in terms of serving veterans and service members and their families?

MS. A. KATHRYN POWER: And this is Kathryn. I want to add that since we have two major events coming up in September, the Workforce Development Conference. Anne Herron and I will be leading that discussion for SAMHSA, which will focus on service members, veterans, and their families behavioral health workforce issues in early September. And then we have the implementation academy on suicide prevention.

And what we've tried to do, Pam, is to ensure that leadership from -- significant leadership from VA and DoD and the National Guard Bureau are all going to be in attendance and witnessing the power of these kinds of technical assistance and trainings, and we hope that that will be an impetus to have some larger discussion across mutual support. So we're looking at that as an opportunity.

MR. CHRISTOPHER R. WILKINS: Kathryn, this is Chris Wilkins. I'd like to weigh in on Administrator Hyde's question just a bit and with a specific area that I think is screaming for focus.

There is no shortage of Medicaid-enrolled veterans showing up in community hospital emergency departments in crisis from alcohol and drug and psychiatric issues. Many of those folks who show up simply don't know the pathway to get themselves enrolled in VA services.

In that particular locality, the infrastructure available to treat the veteran in the VA may have open access. The infrastructure in the community may not. Thus, the disconnect causes lack of ability to access service.

I think one of the key areas of opportunity in the interagency council and the work that's been done is to examine high-risk/high-need veterans with substance

abuse and mental health disorders appearing in community hospitals as Medicaid recipients or uninsured recipients and how to connect them with the right care at the right time. I'm always amazed that I can get on my phone, go to Open Table, and find a table in a restaurant, you know, when I'm in Chicago or Rochester or Poughkeepsie. But I may not necessarily be able to go on my mobile phone and find the open mental health slot in either the VA or in the community system if I'm a veteran.

And those are the kinds of things we can dig in on. I also believe, and I just want to exhort the council a bit, SAMHSA needs to be resourced. People don't go into battle without strategy, arms, men and women, the right equipment, the right fallback plan. And I think the richness that you've brought to this discussion with just a very little bit of resource, I think we're wasting an opportunity if we don't find the right resource so that you can widen and deepen the good work you've already done.

So those are just a couple of thoughts.

MS. PAMELA S. HYDE: Yeah, Chris, I appreciate that. Obviously, anybody who would like to tell our funders, namely Congress, that we need to be resourced, we're happy to have you tell them that. That -- but it is always the issue of what can we do with the limited resources that we have?

The issue that you said earlier I think was a very interesting comment, and it raises for me what I said earlier, and we have with us now Elizabeth Lopez, who's the Deputy in the Center for Mental Health Services. Paolo del Vecchio was here earlier, but we talked just briefly, Elizabeth, about some of our focus on crisis delivery systems.

So I think, Chris, what you're saying leads me to believe that we need to think about this. And Mary, you're doing a little bit of that thinking as well. We need to think about this as we put some proposals together around crisis services is how do we actually make sure that we've got veterans in our eyes' sight when we address those issues?

Part of the thing that HHS is doing is working with VA, and again, Wendy, you can say more about this if you want. But again, a recognition that not every veteran is going to be eligible for VA services and that not every veteran is going to be able to get to a VA facility or, frankly, not every veteran is going to want to get to a VA facility. So we are very conscious here at HHS that getting everyone enrolled in coverage that gives them some options about where and how to receive care is critical for their behavioral health needs.

But your issue, Chris, about how do we make sure that veterans or, more importantly, maybe to say crisis delivery systems, emergency rooms and others, know how to link veterans to the services and the resources that are available to

them is something we should take in. So that's something that strikes me as a really important piece of advice that we need to take in.

Thank you.

So, Kathryn, you want to see if there's any other comments or thoughts?

MS. A. KATHRYN POWER: I was just about to say we are rapidly approaching our end of time assigned to this topic, and I am wanting to ask our esteemed panelists or any of the members of any of the National Advisory Councils if they would like to add one final thought or one final incentive/comment to our discussion?

MS. THERESA GALVAN: [on telephone] Yes, this is Theresa from Navajo area. The question I have in looking at the slides is how does SAMHSA look to ascertain the military cultural competency that is found on page 6 of the slides?

MS. A. KATHRYN POWER: Generally, what we have tried to do is the organizations at the provider level and the organizations at the State level determine what they would like in terms of military cultural competence training. There are at least 10 different military cultural competence trainings that are very effective that are put on by various organizations, including veterans service organizations including the Defense Center of Excellence, including the VA, including a host of other organizations.

And we offer those opportunities to people, and they make a decision about the level of cultural competence training they want to bring in. Generally, it's a 101 level to start. Having people talk about using military language, understanding military rank and structure, understanding the values that underscore military and veterans on a training basis, recognizing the attributes and the characteristics of this population, recognizing the family stressors, recognizing what might be some of the behavioral health issues that are a result of this conflict, particularly in Iraq and Afghanistan, recognizing the period in which they became a veteran. I think Chris mentioned that.

And just becoming aware of how to start a conversation with an individual. Have you ever served in uniform? Have you ever served in combat? Have you or do you consider yourself a veteran? There are many women who don't even consider themselves veterans.

And so, getting to that level where community civilian providers feel that they are confident and comfortable at least beginning to have a conversation. And then there are other sophisticated levels of cultural competence that may be had in terms of whether you work in a VA system, whether you work in a provider like Chris's provider level where they may have a different level that they expect in terms of understanding knowledge about the military population.

So that's -- that's sort of a quick answer to your question, but there are lots of different ways to obtain that training.

MS. PAMELA S. HYDE: So, Kathryn, it also occurs to me, given the questions we've gotten today about the are we paying enough attention or doing the unique things about that training having to do with American Indian and Alaska Natives, that we might want to take one of those cultural competency curriculums and just share it with our TTAC, the Tribal Technical Assistance Center.

MS. A. KATHRYN POWER: I was thinking about the crossover between the two populations, yeah.

MS. PAMELA S. HYDE: Yeah, and just -- just have them react to it a little bit and see if there's something that we might learn from them about that. So we might use --

MS. A. KATHRYN POWER: I think that's a great idea.

MS. PAMELA S. HYDE: -- all of you who are serving on our council members or especially those on the Tribal Technical Assistance, we'll be back to you about that issue. So --

MS. A. KATHRYN POWER: Are there any final comments?

[No response.]

MS. A. KATHRYN POWER: I want to thank our esteemed guest panelists. Thank you so much, Mary Ann, Wendy, and Christopher. And thank you, Pam, for the opportunity. I appreciate the interest and moving forward.

MS. PAMELA S. HYDE: Great. Thanks so much, Kathryn, for all of your work on this. And Stephanie, thank you for your work. You didn't get to say anything today, but I personally know how much Stephanie is doing on this, and she's been working directly with me and with Kathryn and the White House for some time now. So appreciate that, Stephanie, thank you.

Thanks to the panel members, and thanks to all the council members. I would urge you not to go away. One of the things we ask of you is to listen to the public comment because that will help inform you about how to inform us.

So let me just remind you before we go into public comment that the next NAC, Joint NAC and all the meetings, all the advisory council meetings that we have are going to happen April 8th, 9th, and 10th, 2015. So please put that on your calendar, and remember to watch for emails or other things from Holly Berilla, who is our new -- who will be our new, what do you call it, committee

management officer. We have these fancy titles for it's just Holly and Geretta to me.

But anyway, watch for that. And we'll get you more information. But do please put those dates, April 8th, 9th, and 10th, on your calendar.

Agenda Item: Public Comment

MS. PAMELA S. HYDE: We have a couple of people who have been -- who have identified that they want to make public comment. Let me just remind people who have made those comments or indicated to us that they want to do that that if you have questions, we'll be glad to take the questions and make them part of the record. We will not be answering questions on the call today, but we'll get somebody back to you if there's a question that we can answer in some other way.

So the first comment is from Sean Bennett, who lives in Michigan. And Sean, are you on the phone? And I think Kevin -- or I'm sorry, Andrew, this is the time where we need to allow someone who is from the public to come in.

So, Sean Bennett. And we're going to ask each of our commenters to keep your comments to about 3 to 5 minutes so we can make sure we have plenty of time for everybody.

OPERATOR: Sean Bennett, if you could kindly press *, then 1 on your touchtone phone to enter the queue, please. Again, you can press *, then 1.

MR. SEAN BENNETT: [on telephone] Can you hear me?

OPERATOR: Sir, you're connected. Please go ahead.

MR. SEAN BENNETT: Thank you. Yes, hello.

MS. PAMELA S. HYDE: Hello.

MR. SEAN BENNETT: Sean Bennett here. Glad to be here at the meeting today.

I did send in a written comment for the meeting that I hope you got.

MS. PAMELA S. HYDE: We do have that, Sean.

MR. SEAN BENNETT: That was sent to Geretta, and there was a slight correction on this comment. But let me ask you, can you hear me okay there,

Pam?

MS. PAMELA S. HYDE: Yes, we can hear you fine.

MR. SEAN BENNETT: Okay. Yeah, a slight correction on my written comment. I deleted the word "who." The word "who" should be there where it says "Federal criminal laws should be enforced against those who -- against those persons who force persons to consume psychiatric drugs." Anyway, I hope that hasn't confused too many people.

MS. PAMELA S. HYDE: Okay. We got it. Thank you.

MR. SEAN BENNETT: It's just a simple insert of the word "who" on that.

MS. PAMELA S. HYDE: All right. Thank you.

MR. SEAN BENNETT: I did also submit a written question today, and that has to do with assuming that the SAMHSA recognizes and agrees with that informed consent is a basic necessary health protecting right and that patients should -- even mental patients should be respected in that, what actually can SAMHSA do as an executive Federal agency to influence policy? And so, this is kind of a question.

But I'm here to comment, not to answer that question. But I think what I would like to do is persuade SAMHSA and the advisory council members that this is an issue. The right of informed consent for mental patients regarding psychiatric drugs, the issue that I think everyone should study, everyone should be aware of, everyone who knows -- anyone who cares about mental health laws and mental health policies in America should understand this issue.

And I think that Tim Murphy, Representative Tim Murphy from Pennsylvania has really started a debate by going in the opposite direction I'm recommending. He is advocating across the country that we need to have more forced psychiatric treatment laws and that this is something that the Federal Government should fund and that, you know, the States should do more of.

And I'm advocating for exactly the opposite of that approach. And part of the reason that I'm advocating for it is the fact that it's unconstitutional. It's staggeringly unconstitutional. This is a situation where this group of people, mental patients have long been legally disenfranchised. They've never had their rights protected in the courts of law in this country.

If you look and find out -- if you look to the Federal courts and find out how many victims of lobotomies ever sued in the Federal court to establish some constitutionality, you won't find any. The same goes with electroshock treatment. We're looking at about 500,000 victims of electroshock in this country.

And regarding drugging, it's been a pathetic issue. It went to the Supreme Court, Mills v. Rogers, 1982, and then there was the New Jersey Rennie case, and the Supreme Court basically decided they wanted to leave it with the States. So this is something the States should look at.

So it really is a matter that properly belongs in the political arena, in the democratic arena, not to a few unelected judges. They have proved that they -- you know, they're not all that friendly to civil rights. They've been proving that since the Reconstruction era. So it's up to the people to protect the rights of this disenfranchised and historically subjugated group of people.

And so, this is what I'd like for the people involved here to do is to understand the right of informed consent and that it is vital. It is life and death importance that mental patients have this right of informed consent. And what we find is that the drugs are not what the doctors and the drug companies represent the drugs to be. The drugs are much more harmful, much more countertherapeutic than they're represented.

So the mental patients are being subjected to an assaultive fraud that violates constitutional rights and constitutes criminal abuse. This is routine. It's been routine in this country for more than 100 years.

And so, I'm hoping that this group can kind of step up to the plate and take a look at this issue and, you know, realizing there are limitations in an executive agency, but there's also opportunities in a Federal executive agency. Given the supremacy of Federal law, we know that Federal law, the Federal Constitution trumps all State laws and State constitutions.

So if we see that the Federal law protects the right of informed consent, then we have a duty here at this agency to see that State laws to the contrary are they're void. They're nullified. They are abrogated if they violate Federal law. Federal law is supreme.

So we are equipped, I think, to do the job, but it's really now a matter of do we have the knowledge and do we have the will to work on this issue? So is everybody hearing me okay?

MS. PAMELA S. HYDE: Yeah. We're hearing you fine, Sean. Thanks.

MR. SEAN BENNETT: All right. So that's where we are today. I just hope everyone has seen my -- I also had a bibliography, which gives you a listing of the books that talk about the corruption that goes on and the unreliability and untrustworthy of the drug companies, the dangers of the drugs, and so I hope that people can become informed. And I hope, even more importantly, that action can be taken to protect and to secure peoples' rights, everyone's rights

here in America.

So thank you very much.

MS. PAMELA S. HYDE: Thank you, Sean. Appreciate it. Your comments, your bibliography, and your question are all part of the record, and we will also offer your question to a couple people who may have comments or help answer some of that.

Thank you. Appreciate it.

So next person that we have on the line. So, Andrew, this person, it's Janet Colbert or Maureen Kielian, K-i-e-l-i-a-n. Both of them collectively asked for public comment. So can you see if they're on the line?

OPERATOR: Okay. If that location would kindly press *, then 1 on the touchtone phone to enter the queue? Once again, *, then 1.

MS. PAMELA S. HYDE: So either Janet or Maureen.

OPERATOR: Okay. We do have Maureen Kielian to join. You are connected.

MS. PAMELA S. HYDE: Okay.

OPERATOR: Ms. Kielian, your line is open. Please go ahead with your question. You may need to unmute your phone. It is open on this side. Please go ahead.

MS. MAUREEN KIELIAN: [on telephone] Hello, this is Maureen.

MS. PAMELA S. HYDE: Hi, Maureen. You're on. Go ahead.

MS. MAUREEN KIELIAN: Thank you. We have -- we're an organization in south Florida, Broward County, Florida, to be exact, the epicenter of the prescription drug epidemic, physician-prescribed drug epidemic, and we're very concerned about our veterans and the abuse of the system. Particularly it's easy to prescribe because it takes less time than an office visit.

In saying that, we have been advocating for quite a few years because the Florida mortality rate due to the overdoses is astronomical, well over 11 a day, although I think now we might be down to 9 a day. But we'd just like to introduce ourselves and what we're trying to do. So Janet and I have been in contact with the ONDCP with regard to the strategy -- 2014 drug policy, the whole strategy policy.

We're very concerned about our veterans. We're also in collaboration with an

organization called Fed Up, which will be in Washington, D.C., on September 28th. It's a rally. Janet and I have made schedules with the DEA, the CDC, the ONDCP, to bring light to this epidemic, national epidemic.

We also on that day, Sunday, September 28th, we do have a veteran speaking. It's on Washington Mall. There will be a little rally there, peaceful sort of protest type of thing. And we're real thankful for that veteran because I believe that, you know, that part of the picture with the VA scandal right now, certainly the overprescribing of opioids and psychotropic drugs could be addressed.

Let's see, what else do I have here? The healthcare dollar. You know, I listened to the whole, everybody's speech and everybody's programs and everybody's concerns and what not. Well, to me, to us, you know, everybody is worried about rehab, where we're going to send them, crisis intervention. Yes, and that is true, and we believe, you know, that we need to improve those systems and get rid of the stigma. But we have to look at what started this problem.

And that is, as the previous caller in said, the fraud by the big pharma companies and truly an informed consent. A true explanation of what these drugs can do to a person. That -- I think that's pretty much my two questions. We look forward to perhaps working with more Washington representatives in stopping this horrible physician issue, physician quality control issue.

Thank you.

MS. PAMELA S. HYDE: Thank you, Maureen. Appreciate it. Your comments and your questions are part of the record, and we will have folks follow up.

We are, as I said earlier, I assume you were on the phone, I said we were doing quite a bit of work on prescription drug and opioid overdose and opioid addiction with our Federal colleagues. So your input is useful in that, and in fact, in some ways, we've looked to Florida and other States for models and ways that we can do that. I think your comments about making sure that we do that in ways that veterans are included or specifically identified is also very good input.

So thank you for that.

We have one other person that asked to comment, James Gallant of Marquette. James, if you are on the line? Andrew, if you find James, James Gallant, G-a-l-l-a-n-t.

OPERATOR: Hello, Mr. Gallant, please press *, then 1 on your touchtone phone, and then we can take your question, please. Again *, then 1. And we have him now for his question. Your line is open. Please go ahead, sir.

MR. JAMES GALLANT: [on telephone] Hello. Yes, can you hear me good?

MS. PAMELA S. HYDE: We can. But if you can speak closer to the microphone, it would be good.

OPERATOR: Thanks, and I've increased your volume, sir.

MR. JAMES GALLANT: Okay. Thank you for the opportunity here.

And my comments, I have two comments. And the first one is about the cultural competency component, and like the one lady was saying is about family structure, and that what I've noticed in the SAMHSA and it's not only for the military and the veterans, but it's kind of across the board is that included in cultural competency is the broken homes and the divorce and separation in the families, which is considered a cultural issue because there's nearly 40 percent of children are raised in non-intact homes.

And we have a lot of veterans that are coming back, and they're facing divorce and separation as part of their issues. And we are looking to and hoping that you folks will consider including across the board in the SAMHSA, in the Medicaid, in everybody that's getting Federal funding for their services that they would identify their court-ordered custody and parenting rights.

In Michigan, they're required to do that. Well, they're required to assess their need for legal services. Except what we've found in Michigan, in your substance abuse coordinating agency here in Marquette, Michigan, is that they don't. They say they do that, but they're not specifically for custody and parenting issues and family court issues.

And that to directly link these folks back to the family court that issued the court order -- I mean, it's supposed to be every other weekend and Tuesday to, you know, a maintain a relationship with the family and the children that they don't live with -- and it's not followed up by the system. And they'll just say that's a legal issue. You have to go and, I guess, hire a lawyer or do something, something other than it's incorporated into their assessment and to link them directly back to the court.

Because there is an entitlement opportunity, in Michigan anyway, that any member -- any person involved in a court case has the right to entitlement to enforcement services. Because every court has what they call the Office of the Friend of the Court, which they have lawyers and they're there to do that. And there is no cost to the person or the agency, the referring agency.

And it helps adjust the conflict and dysfunction in these people's lives really upstream that would then lead to the depression and would lead to the substance abuse. And especially for people that -- I've known people that they've been separated for years. They just never got around to legally

separating or divorcing, and they're just separated, and alienating these veterans from their families and their relationships. And I think it would be important to just to have that as a part of the services that are available for people that need it.

And also we have here in Michigan, we do the use of SAMHSA funding to create coalitions and workgroups and committees and different configurations to give recommendations to the Federal agencies. And what we've found is a lot of these people are saying, well, the coalition is just two or more people sitting in a room and we're discussing these issues.

And there's no structure at all. There's no voting. There's just one person that's by acclimation saying the group has agreed to something when they really didn't. Nobody agreed or disagreed. They're denying them the right to vote.

So a lot of these people, when you're talking about peer support and you're talking about peer coaching and veterans, to help veterans that have been there, and you know, you have vulnerable citizens that are being appointed to these groups that they're not being protected. They're being bullied themselves into accepting what the group wants and what a lot of these folks -- and I've found this in suicide prevention programming in Michigan, with the State suicide prevention plan in Michigan, and the county plans, are all going along this structure to where they'll have several interested -- they'll call them interested individuals in the agencies around the community, and they'll form a -- say they're a coalition and create a recommendation, and then all of a sudden, that's our country plan.

Let's say it's Marquette. It's Marquette County suicide prevention plan, except it's not by the county. And in Macomb County and Shiawassee County and most every country in Michigan that has a suicide prevention plan is not approved by the county board of commissioners, which is supported by the National Strategy for Suicide Prevention. And so, I was hoping to touch base with you folks and hope that you would encourage and support the implementation of the National Strategy for Suicide Prevention, which fundamentally comes down to is the county board of commissioners in every county in the whole United States would initiate the process.

Because then we have due process. We have public meetings. You have a reasonable opportunity for comment. You know, you go around to these local groups, and they're like, well, this is a private meeting. This is nongovernmental. This is not a public function. This is outside the open meeting, the sunshine laws.

And then they come back, and then they'll have the Department of Community Health in Michigan, a private group brought the recommendation, and then they just signed it. They didn't have any vetting, public vetting, and no public

comment or nothing. And so, I've been told that there is some sort of standards for a coalition, what a coalition means. I mean, what is the definition of a coalition?

Well, you have an interagency agreement, common goals. You have, but that's not what's happening locally. So my fear is that a lot of these recommendations that are being brought forward are actually, you know, the product of contract providers. They'll get a group together, and everybody will just go along with them, what they've always done and what they're saying, without any voting to say this group has voted. A majority of this group approves this.

And so, I was hoping that you folks will consider in the site review process, you'll say, well, this is a coalition. Well, what is your governance structure? Do you have any bylaws? Do you have any rules of procedure? And most of the time, the answer is no. It's they're winging it, basically.

And it's just wrong. There's a lot of bullying going on. With especially these vulnerable citizens, they're being put into these groups, and they are just happy to be there. They're happy that they don't want to lose their invitation to come back. So they just go along. And so, that's not really getting their genuine input as a person with experience.

MS. PAMELA S. HYDE: Thanks, James. I'm going to -- I think we got your comment. We have your questions in the record. I think that there may be some local issues you're raising here. So we'll try to get our regional administrator to talk with you and see if we can talk a little bit more with you about the issue.

Each of these issues that you are raising have a tendency to be State specific or local specific. So, and --

MR. JAMES GALLANT: Right.

MS. PAMELA S. HYDE: -- we'll get somebody to talk with you a little bit more. So is there anyone else from the public that is -- has signed up for making comment or that wants to make comment? Andrew, if you can see if anyone else from the public is interested in speaking?

OPERATOR: Okay. Again, if there is anyone else, you may press *, then 1 on a touchtone phone. Again, *, then 1 for public comment from anyone else.

[No response.]

OPERATOR: Currently, we're seeing no one else in the queue area.

Agenda Item: Closing Remarks and Adjournment

MS. PAMELA S. HYDE: Okay. Thanks a lot, Andrew. And thanks to all of you in the public who listened today and for your comments. And you've raised some good issues for us, and we'll pursue those with you.

And again, to our advisory council members, thanks so much. We're interested in any feedback that you have as we try to do these virtual programs. We always struggle with the balance of getting you information and having a panel of folks from the councils and, as you have requested us to do, from other Federal agencies. So today we had someone from the VA, and we really appreciate Wendy's involvement today.

So we're trying to always balance how to get you information and have you hear from some of those interactions that we do regularly and how to get you up to speed quickly on things we're working on or have done and, at the same time, give you an opportunity to comment and question and give us the advice that we are asking of you.

So your feedback would be most helpful. If you have any feedback about the meeting, please send it to Geretta, and she will make sure that Holly gets it as well, as we try to plan for April 8th, 9th, and 10th for our next face-to-face meetings.

And once again, before we sign off here, I want to again invite all of you to participate or at least listen in tomorrow while the National Advisory Council talks about where we are with health reform as a department and where some of SAMHSA's efforts around health reform, healthcare, and health systems integration, around our parity work and other kind of health financing issues. So that will be the topic tomorrow from 1:00 p.m. to 4:00 p.m.

And there should have been public information sent out about how people get to that. Is that right? So to all of our council members should have that, right? So if anybody doesn't have that information, they also should email Geretta Wood. That's G-e-r-e-t-t-a.Wood -- W-o-o-d -- @samhsa -- be sure you spell that right -- s-a-m-h-s-a.hhs.gov.

So Geretta.Wood@samhsa.hhs.gov if you have any questions about getting on and listening to tomorrow's call with our National Advisory Council. And for those you on the phone who are our National Advisory Council members, we look forward to talking to you tomorrow.

Thank you very much, and thanks to all the technical people, Josh and Irene and Sarah. Thank you very much for your help as well.

Thanks a lot. Bye.

OPERATOR: The conference has now ended. Thank you for attending today's presentation. You may now disconnect.

[Whereupon, at 3:27 p.m., the meeting was adjourned.]