

**U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration**

**55th Meeting
of the
SAMHSA National Advisory Council (NAC)**

**April 4, 2014
Sugarloaf Conference Room
1 Choke Cherry Road
Rockville, MD**

**Transcribed by:
Alderson Court Reporting
Washington, D.C. 20036
(202) 289-2260**

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Committee Members Present

Geretta Wood, DFO
Eric B. Broderick
Henry Chung
H. Westley Clark
Paolo del Vecchio
Kana Enomoto
Suzanne Fields
Mary Fleming
Junius J. Gonzales
Megan Gregory
Frances M. Harding
Marla Hendriksson
Lorrie Rickman Jones
Laurent S. Lehmann
Charles Olson
Elizabeth A. Pattullo
A. Kathryn Power
Cassandra Price
Dee Davis Roth
Josh Shapiro
Abby Smith
Benjamin Springgate
Christopher R. Wilkins
Marleen Wong

PROCEEDINGS

Agenda Item: Call the 55th SAMHSA NAC Meeting to Order

OPERATOR: Today's conference is being recorded. If you have any objections, you may disconnect at this time.

Now I would like to turn the meeting over to Ms. Kana Enomoto.

MS. GERETTA WOOD: Good morning, and welcome to SAMHSA --

OPERATOR: Ms. Enomoto, you may begin.

MS. GERETTA WOOD: I'm Geretta Wood, SAMHSA's committee management officer, and as the DFO of the SAMHSA National Advisory Committee, I officially call this meeting to order.

Before we begin, I just have a few brief announcements, and I'd just like to remind you to please speak into your microphone. Make sure you turn the microphone on and please identify yourself for the transcriptionist.

Mute your computer speakers if you're calling in over the telecon so that we don't get feedback, and we do have, I believe, a couple of members that are on the teleconference.

The contractors today are Josh Shapiro and Abby Smith. If you have any technical difficulties, please contact Josh Shapiro at jshapiro@capconcorp.com.

And Kana, I note for the record that voting members present constitute a quorum, and I'll now turn the meeting over to Kana Enomoto.

Agenda Item: Welcome, Opening Remarks, and Consideration of Minutes from the August 2013 SAMHSA NAC Meeting

MS. KANA ENOMOTO: Good morning. I'm Kana Enomoto, Principal Deputy here at SAMHSA, and I'm not Administrator Pam Hyde, who is unable to join us today because of a death in the family.

So I will be chairing and to begin us, we'll do a roll call of our members of the SAMHSA National Advisory Committee.

Should I start with Junius?

DR. JUNIUS J. GONZALES: Junius Gonzales.

MS. DEE DAVIS ROTH: Dee Davis Roth.

MR. CHRISTOPHER R. WILKINS: Chris Wilkins.

DR. ERIC B. BRODERICK: Ric Broderick.

DR. LAURENT S. LEHMANN: Larry Lehmann, ex officio from VA.

MS. CASSANDRA PRICE: Cassandra Price.

MS. ELIZABETH A. PATTULLO: Betsy Pattullo.

DR. MARLEEN WONG: Marleen Wong.

MS. MEGAN GREGORY: Megan Gregory.

DR. HENRY CHUNG: Henry Chung.

MS. KANA ENOMOTO: And as a first order of business, I'd like to review the minutes from our August meeting. These minutes are in your binder under Tab 2 from the August 16th meeting of the SAMHSA National Advisory Committee. These minutes were certified in accordance with the Federal Advisory Committees Act regulations. Members were given the opportunity to review and comment on the draft minutes.

Members also received a copy of the certified minutes. If you have any changes or additions, they will be incorporated in this meeting's minutes. Are there any changes or additions?

[No response.]

MS. KANA ENOMOTO: If not, then may I have a motion to approve the minutes?

MS. ELIZABETH A. PATTULLO: So moved.

MS. KANA ENOMOTO: Betsy Pattullo has moved to approve. Is there a second?

DR. JUNIUS J. GONZALES: Second.

MS. KANA ENOMOTO: Junius Gonzales has seconded.

The minutes are approved.

Okay. So we get to start this morning with -- well, we're going to start with a good-bye for the three members who have served on the SAMHSA National Advisory Committee since June 2011, and this will be their last meeting? Their last meeting.

MS. GERETTA WOOD: This is the last meeting they will be here in person. They will participate in August by teleconference.

MS. KANA ENOMOTO: Right. Okay. All right. So the first person I would like to recognize and thank is Dee Roth, who was the Chief Program Evaluation and Research at the -- chief of Program Evaluation and Research at the Ohio Department of Mental Health for over 36 years. She has been a wonderful addition to the SAMHSA National Advisory Committee and very, very active and, as a role model to the rest of you, has volunteered often to participate in conversations with our SAMHSA senior staff.

I know that Pete Delany has appreciated her active advice and involvement in what we're doing in our Center for Behavioral Health Statistics and Quality and thinking about our data efforts and our emerging Behavioral Health Quality Framework.

So, Dee, I really appreciate -- I know that the Administrator has absolutely appreciated your participation, and the rest of SAMHSA has benefited from your expertise and your active engagement. So thank you very much.

[Pause.]

MS. KANA ENOMOTO: So this is presented to Dee Davis Roth with appreciation for your outstanding tenure on the Substance Abuse and Mental Health Services Administration National Advisory Council and gratitude for your tireless support, advice, and insights to the benefit of SAMHSA, the Department of Health and Human Services, and the people we serve. April 2014.

Thank you.

[Applause.]

MS. DEE DAVIS ROTH: I hope you are planning to send me that, not take it on the plane. That might not go through security.

This has been such an honor for me to do this, to be here to hear these kinds of conversations. I've loved watching Pam work, again because I worked for her for 7 years in Ohio.

I think the nature of the discussions and the kinds of people that are at SAMHSA are so impressive, and it just has been wonderful to come over here each of these meetings.

Thank you.

MS. KANA ENOMOTO: Thank you.

Our second member is not with us today and will possibly be joining us later by phone. Oh, he is on the phone? All right. Well, wonderful.

That is Benjamin Springgate, who is a physician and health researcher, and in addition to serving as the Executive Director of the Community Health Innovation and Research in the Office of Community Affairs and Health Policy at Tulane School of Medicine, he is also the Executive Director of Community Health in Tulane's Section of General Internal Medicine and Geriatrics and holds adjunct positions in the Tulane Departments of Psychiatry and Pediatrics. He's the Director of Health for the Rand Gulf States Policy Institute, located in New Orleans, Louisiana, and serves as president of Reach NOLA.

Dr. Springgate has been a wonderful presence also on our National Advisory Council, particularly in times of emergency and disaster, providing really valuable insight on how we, as an organization, could better respond in times of disaster to the mental health and substance abuse needs of communities, as well as an active participant in the conversations, particularly that involve psychiatry and the integration of behavioral health and health and how SAMHSA could take a leading role in advancing those efforts.

So, Dr. Springgate, thank you very much. Would you like to say a few words?

DR. BENJAMIN SPRINGGATE: [on telephone] It's been a pleasure, and I appreciate the opportunity to participate in this way.

Thank you.

MS. KANA ENOMOTO: And our third member who is cycling off is Marleen Wong. Dr. Wong is assistant dean, clinical professor, and Director of Field Education at the University of Southern California School of Social Work and administrator for a new virtual academic center and all internship programs in Los Angeles, Orange County, San Diego, and West Los Angeles, consisting of 1,100 graduate students. Just a small catchment area.

Dr. Wong has worked as the Director of School Crisis and Intervention at the National Center for Child Traumatic Stress at UCLA and is the former Director of Mental Health Services, Crisis Intervention, and Suicide Prevention in the Los Angeles Unified School District. As a really internationally and nationally known expert on child trauma, particularly in schools, we have been very fortunate to have Marleen on the National Advisory Committee. She's a resource not only to SAMHSA, but to the field in this area, and we have been really, really very fortunate to have her.

So thank you, Marleen.

[Applause.]

DR. MARLEEN WONG: Well, it's been an honor to serve on this national council, and we have taken everything to heart. I've learned so much from listening to the conversations around this table and really attempted to apply it in every instance of the work that I do, both nationally, internationally, and at the University of South California.

So, in the past year, we've grown to 3,200 students, and I'm now an associate dean, and the whole idea of bringing all of the evidence-based practices to the field is something that is really what we're trying to do and build the workforce so that they'll be more effective in dealing with children who have a range of mental health challenges.

Thank you.

MS. KANA ENOMOTO: Marleen has been a tireless advocate for us to work with the schools and never forget that that's where children are. So we appreciate that.

Agenda Item: Reflections on Joint Council

So I think this morning we're going to start off with some reflections from the group about yesterday's conversation. It was a very lively and a little bit long day, but I was really pleased to see so many of the members really actively engaged. I think we had a great round robin, refuse to call it speed dating experience with the strategic initiative leads.

And while Mary and I sat in the corner waiting for people to talk about in Group 7 those issues that weren't covered already, we didn't get many takers. So I feel like people were really, really engaged at their tables in the topics that they had and also that there's a broad sense that those are the right six. Those are the right strategic initiatives for SAMHSA to be focusing on.

But I know that we heard also from you and from all the councils about the integration conversation, about what we need to be looking at as we are moving into a new era of healthcare and bringing behavioral health and broader healthcare together. And we had some advice that we heard from the councils around financing and contracting issues that we need to be looking at, about communication work that we need to be doing, and it'll be great that we have Marla Hendriksson, the Director of our Office of Communications, here to talk more about what resources and strategies we have at SAMHSA, but how we should be communicating differently with the field to help advance integration.

Also workforce issues. As you know, that's going to be our new strategic initiative moving forward, but the workforce issues related integration are both many and complex. And so, I think your help in thinking that through and what SAMHSA could do and where sort of the sweet spots are for our involvement will be very useful.

And HIT/electronic medical record issues. That came up. That popped up, I think, pretty consistently throughout that conversation about how we need to really embrace technology, and I think the Administrator shared that we are really taking a hard look at 42 CFR Part 2 and how -- what changes might be needed in that domain and how the electronic medical record, how HIEs, how the sharing of data is really going to change the way care is managed, received, and provided.

So, with that, I'd like to open it up to you all for other observations, insights, comments about yesterday's SI -- either SI conversation or the integration conversation.

[Pause.]

MS. KANA ENOMOTO: As you are mulling it over.

MS. DEE DAVIS ROTH: The thing that stands out most for me is a tiny little nugget that came from the youth panel. I think it was Johanna that said kids don't understand what the word "trauma" means, and she elaborated on that a little bit in the small group. And she said they just think of it as their crappy life, not that, you know, something has happened to them.

And I remember from Ohio when we were starting into the whole trauma education thing for ourselves and how many "aha" moments people had, and one of the consumer leaders in one of these meetings where, you know, here is what trauma is, here is what it does to you, et cetera. Sat and said, "My God, no wonder I'm so screwed up." And he was happy about it.

I mean, it was sort of like a thing that made it click. So I think if the youth

generation of today is not getting, understanding that message, that's one of the things that SAMHSA could do some more of.

DR. MARLEEN WONG: Well, I think SAMHSA has done a great deal through the National Child Traumatic Stress Network, and I think in the last couple of years, what we've -- I guess for me what's been pretty startling is the extent to which all populations experience trauma. I mean, the work that I began with Rand back in 1997 had to do with assessing the exposure of children to violence, and very high rates, of course, in South L.A. and East Los Angeles.

But after working at Newtown and looking at what's happening right now at Fort Hood, I think that that experience is spreading across the population as a whole, and I remember listening to a Harvard researcher say that violence was a public health problem. And just like public health problems, they begin with the most vulnerable populations, and then they spread.

If things aren't done to mitigate those conditions or to prevent the spread of that experience, that disorder, it will spread across to all classes, to all populations. And I think it's happened.

MS. KANA ENOMOTO: Other thoughts? Suzanne, you were our leader and facilitator on the integration conversation. We have also Mary Fleming and Kathryn Power joining us at the table.

Chris?

MR. CHRISTOPHER R. WILKINS: Thank you, Kana.

You said it again this morning, the thing that I've been thinking about all night, which was -- if I captured the words right -- how should we be communicating to the field to advance integration? And I came away from the SI discussion and the communication discussion thinking this is lovely. It's well reasoned. It's well planned. But I was getting the sense that the agency, in terms of its core operations, is banked to doing pretty much what it's had to do over the years to take care of the \$3.6 billion in contracts and then working really hard, perhaps in a very stretched way, to have to deal with the rest.

And it felt like a discussion about retooling the rest, right, in terms of the SI stuff. It left me -- left me thinking about my experience of integration, which is the folks driving integration on the ground in communities are generally the constituency that belongs to the American College of Healthcare Executives and the associated physicians and professionals in health systems. They're holding the patients, the bricks, the mortar, the facilities, the capital.

And when we go back into the field that's being fed by the \$3.6 billion, at least the data that I've seen says that when they're approaching accountable care

organizations, only a third of the time does the accountable care organization buy services from the folks that are in the field. That means two of the three times they're building it themselves.

So if they're building it themselves, they need every shred of expertise that SAMHSA has got. They need to know everything that we've got in the TIP series. They've got to know all the science, all the history, all the experience that SAMHSA has developed in this very rich tradition of intellectual capital and people.

So the SIs and the communication strategy, while lovely and well planned, left me wanting something radically different. Can we look at the Nation and say we've got an answer for this opiate thing? This is a big deal.

One of the biggest drains on the public Treasury is infants in full opiate withdrawal syndrome when they're born. It's costing Medicaid hundreds of millions of dollars in this country.

Have we got an answer for gun violence? If you think about what dominates the national consciousness at this time, people are being driven by those two things. Do we have a coherent way to walk into the constituency of the American College of Healthcare Executives and the American Medical Association and the American Psychiatric Association and the Nursing Association and say, "Let us tell you everything we know about behavioral health, and here's the translational science that you can draw upon when you're doing integration."

Can we look at not just the technologies that we know about, but the disruptive technologies that are emerging to really drive the new world? I think I made the comment yesterday. We do innovation in a way at CMS and at SAMHSA and everywhere else where if you're really well organized, then down the road, you can apply and get some support for your innovation. But how do we account for Steve Jobs and Steve Wozniak and a guy from healthcare sitting in the garage saying, you know, we got a better idea about that? How do we stimulate micro-innovation incubation?

So I was left saying our thinking is good, but rather than stretch ourselves into that little bit of stuff while we're banked to a big legacy model that hasn't really changed, how do we throw all that away and do a different thing?

MS. KANA ENOMOTO: I'm going to let Henry respond, but I just want to note that we do have at 9:45 a.m. the conversation about SAMHSA's leadership role in healthcare integration. So I think that will be time to further explore kind of what is it that you would see us doing to have that kind of influence, and how might we achieve that?

So, Henry?

DR. HENRY CHUNG: Just also to apologize to the committee, I need to leave at 10:00 a.m. So I'm going to try to inject as much of my enthusiasm and passion in this area of integration as possible in my comments.

I think, you know, Chris is absolutely correct, particularly around the area of disruptive technologies and micro-innovation. I think we have to be open-minded enough as a field to begin to let some of the innovators in in the way that we traditionally have employed our community-based models, which tends to be very people intensive. And people intensive is great, but as we heard from our youth group yesterday, technology is becoming the bridge to overcome the limitations of face-to-face.

And a lot of our models in behavioral health are really driven by face-to-face models, face-to-face thinking, that everything has to be done face-to-face and they have to be done in these 50-minute sessions. These are conventions, and these conventions need to go away. And we need to challenge ourselves about these conventions because challenging ourselves and those conventions will allow us then to think about what it means for payment reform, a different way of providing a reimbursement structure for value, and outcomes.

The other piece that I think is very important was the HIT thing. I thought that General Clark really had the pulse on what the critical need is there in HIT because you can't do integration without having a standard set of terms and expectations that we're expected to communicate within our own field and with the larger field that we're going to really integrate.

So it needs to make sense. There has to be an orderly structure to data and that data can be used for future study. But I think what our field brings to the table in terms of HIT, as I said yesterday, is to try to make many of the risk factors that we're aware of in our work present in the electronic medical record or present in the electronic health record because those things which clinicians really find important, like unstable housing situations, like other psychosocial risk factors including trauma, that those things are not captured anywhere except in text. And in text, it's right now not helpful in terms of us defining our population and really demonstrating the need.

The third thing I'll say is that the final comment at the end I thought hit me pretty hard, which was the discussion around sort of the public health approach that SAMHSA needs to take, and it feels to me that we need to articulate what that means. And it may mean issues like what Marleen brought up around issues of trauma and violence, hot spots in terms of what we're seeing in the opioid arena and the types of things that Chris is talking about.

And to me, the essence of good public health is sort of these early signals/early warning tracking around it and then being able to really say we've got a crisis.

Here are the immediate steps that people need to do. And we see that a lot from the CDC, but if SAMHSA really wants to have that agenda, it needs to articulate what that public health agenda means and what the mechanisms for effectuating that goal, how that's going to happen.

MS. KANA ENOMOTO: Thank you, Henry. Betsy?

MS. ELIZABETH A. PATTULLO: I agree with what both of you gentlemen have had to say. I think the other thing that came across to me yesterday, and I think Dr. Huey spoke to this, Leighton Huey, you know, we have examples of where integration is working, where there are disruptive technologies that are being applied, where there really are answers to some of the problems that Chris and Henry are talking about.

And I think one of the roles that SAMHSA could play is to shine a light on examples, concrete examples of where things really are working in practice. And I would just urge, given the perspective that exists here, that that be taken advantage of.

DR. ERIC B. BRODERICK: I agree with what you said, Chris, from a little bit different perspective, though. I was just thinking last night about, and I talked to a few of the SI leads about sort of the nature of SAMHSA's work on just the bread and butter, their getting the grants out and what that takes for the people in this building. And as I looked at the strategic initiatives, I don't know if you've done an analysis of what percent or proportion of your resources go to support that, I suspect is a fairly small amount.

With the exception perhaps of what Paolo and Fran are doing, SAMHSA is not a workforce agency. SAMHSA is relying on others to do that. So I understand the strategy of putting a strategic plan together that shows that SAMHSA thinks this stuff is important, is going to work with its Federal partners to try to accomplish it. Because largely that stuff is going to have to be accomplished outside of this building and measured, hopefully, by SAMHSA and with SAMHSA as an active partner within the Federal system to make that happen.

So that's a good strategy for sort of keeping SAMHSA on the map and engaged with other agencies that have choices to make about how their resources are spent. I guess the comment that I would make sort of about the toll that that takes or the requirements that that imposes on the agency is that it does, as Chris said, spreads things fairly thin, and I don't know how you're going to deal with that, quite frankly.

But I think to acknowledge it, that it happens and it will happen. It may make it difficult to respond to things that are unforeseen that come up that whether it be a new something. I don't know where you find the resources to draw upon to do that. So it will come with a price, at a cost or an opportunity cost lost, if you will,

to respond to something else.

But it's hard to fault the stuff. I mean, you know, it's all really important, and there are sectors of the country that care very much about them, and SAMHSA needs to be in a role to play at that table. But I don't know sort of how you deal with the need to do sort of other stuff that the public really needs, too. So you can't have a public -- can't have a strategic plan that's 600 pages and touches everything, but there's going to be things that are difficult.

MS. KANA ENOMOTO: I think you have identified one of the core issues that we've been grappling over the last year and a half as an ELT and why we went along the route of these internal operating strategies. Because the wheels were sort of about to fall off the bus with the strain of having the eight strategic initiatives that we had before layered on top of a programmatic portfolio that, to a greater or lesser extent, supported those eight SIs.

I think we did a pretty masterful job with the leadership of all the center and office directors and the staff in aligning the programs that we did have with the SIs. So the block grant is the biggest portion of it, and that really took on a health reform, health systems integration lens, right? So that -- so while it's not a -- it wasn't a direct line of health reform funding, we said the health part -- a big role of the health reform strategic initiative is to look at how do we help the block grants adapt, modernize, and fit in with that new arena?

And I think, similarly, the other parts of the portfolio were aligned with the different SIs in that way. So while we didn't get dedicated HIT funding, Dr. Clark was very savvy in his leadership and his strategy around bringing pieces of the portfolio to support those efforts. And military families, I mean, part of the reason why we don't have a military family strategic initiative moving forward is that we don't have dedicated funding for military families activities.

And while we have the vast majority of our grants identifying service members, veterans, and military families as a priority population, we don't have a military families grant program. We don't have a military families line, and so that's sort of, as we've noted, it's gotten integrated into the warp and woof of what we do, but falling off as an SI.

And workforce, because we did get this \$56 million investment in workforce in 2014 and, hopefully, 2015 and moving forward, we are able to elevate it as a strategic initiative. But absolutely. I mean, Mike was talking about it, but it was such a complex issue I don't know that it all came across -- it could come across in 10 minutes.

But this talent management conversation that we're having and our business process conversations that we're having and the resource investment internal operating strategy, that's really about we can't keep hiring in the same way we've

hired for 20 years and have an organization that's going to be a different one in 20 years from now. All right? We have to hire differently.

We have to structure differently. We have to organize and think through how we're managing our grants and our contracts and doing our bread and butter work maybe a little bit differently so that we can free up that extra 20 percent of our time and energy that we're needing to use to do that kind of technical -- provide that technical expertise or do that policy work.

And what we've done, we've done an amazing amount of policy work in the last 4 years, but we've done that on top of sort of our day jobs. And what we're doing in the talent management conversation and others is figuring out how do we actually embed that as part of the day job so that it can be done within 40 hours a week and not ask everybody to run ragged to 50, 60 hours.

DR. ERIC B. BRODERICK: When's the last 40-hour week you spent, Kana? I mean, you make the point is that's done at a cost, and the cost is an overlay. I mean, I know the hours that you spend, and so I think it's wonderful. And you don't have to hire a lot of people, different people. But a few, strategically placed within this building, do marvelous work. I mean, I've seen that firsthand.

And so, I think that's wonderful, and I suspect what it's like to get a grant out the door is not a lot different. But in terms of sort of the back and forth that goes into it. But I'm just not being critical. I'm just asking a question in terms of what it takes and can you sustain it? Even hiring different people, there are still so many people in the building and to get the work done, and I know you've thought a lot about it, and I'm thinking about it, too.

MS. KANA ENOMOTO: Kathryn and then Chris.

MS. A. KATHRYN POWER: I would be remiss if I didn't comment that I think other than the commentary I've already heard this morning, the nature of our business is changing at the same time in terms of the fact that we, out now in the regions, are reflective now of 50 different States with 50 different healthcare systems, all of whom are trying to gauge what their systems are going to look like.

And therefore, our response capability has to reflect that, and we're now sort of a pipeline back to the stellar staff here. And that's another level of work, Dr. Broderick, that is going on at the same time, that we are -- we are demanding some support for our role in terms of building a regional contiguous presence around SAMHSA, reflective of our response to the State behavioral health leadership and the State healthcare leadership, no matter what their exchange looks like, no matter what their healthcare system looks like.

And it's all moving. All these tectonic plates are moving. And so, that adds, I

think, an additional sort of interesting perspective to the reanalysis of business practices.

I see they've shut me off already. Honest to God, it's much better than being yanked out into the hallway. So it's just an observation I have now in terms of looking at that role.

MR. CHRISTOPHER R. WILKINS: Kana, I don't want to pile on too hard on this, but just to put a fine point on it. I'm not going to get this right, but when observing the Russian folks being persecuted by the tsar, Mark Twain observed that, well, rather than confront him directly and get out of hell, they just decided to lower the temperature a few degrees.

And I only ask it as a reflective question for the ELT and the staff. Are you getting out of hell in terms of this? You guys used the word "overwhelmed" six times yesterday, and "stretched" was used three times. Really within yourselves ask the question, are you lowering the temperature a few degrees, or are you doing something a lot different?

I think there's a lot of strong will around the table to say, okay, let's think about what different might be.

MS. KANA ENOMOTO: I think we are -- I mean, it's true. You're perceptive, and see, Ric, what you've started. But yeah, I mean, I think we're a tired group of people. We're working hard.

We have the best group of executives. They are so smart, and they are so dedicated, and our staff, too. Everyone is trying so hard to keep up with the level of change with a portfolio that hasn't necessarily kept up with that change or sort of a structure of SAMHSA and perception of SAMHSA that hasn't kept up with the changing role.

But that is why, you know, with the internal operating strategies, I hate to keep going back to that, but it is -- you know, part of the policy piece is to and the communication piece is how do you change the perception of the organization? How do you use policy to change how people view SAMHSA, fund SAMHSA, you know, hold SAMHSA accountable so that we can -- we're not just producing widgets anymore. We're doing these other things. But if those are of no value to our stakeholders, then we still have to produce the widgets while doing the other things on top of that, right?

So that's a whole policy and a communications effort to go through. And Ric, you're right. All this additional effort, if we're really going to do it well, it's going to come at a cost. And rather than make it a cost on our work-life balance, which I think has been sort of for the last 4 years, we'd like to try to look at where are the opportunities in our portfolio or in the way we do business to be more efficient?

That's obvious.

But then where are the other things that we just have to give up? We do an A-plus job right now, and we're going to have to do a little bit less of that and help people understand, kind of conceptualize the value of the other things that would be replacing it. So an example of that is that we have -- it's sort of -- we have people that take heroic, lifesaving efforts to save a failing grantee. Lots of site visits, lots of technical assistance resources, lots of money spent trying to save a grantee that's not doing well.

If you talk to one of our project officers, they'll be like, oh, it becomes a half-time job when you have a grantee that starts floundering because we are so loath as a practice to say, you know what, we're going to hold you accountable. We're going to give you this X amount of technical assistance, and then if you fail again to meet your numbers, we're going to start taking -- there will be consequences, right?

And we've been loath to do that. We just have a very caring workforce that says, no, no, no. We have a responsibility to save everybody. But in fact, you know, perhaps we could save some of that energy and say but if you instead of saving that one community, that one poorly functioning grantee, maybe you could be doing technical assistance. You could go meet with the American Academy of Child Psychiatrists. You could go meet with, you know, the American Pediatric Association.

I mean, you could be spending your time having a greater influence and having more impact and yet with the same amount of time, if we could accept this other outcome. But we, as an organization, have to accept that alternate outcome. You know, our stakeholders have to accept that alternate outcome. The people that give us money, that run our budgets, things like that, they have to accept those alternate outcomes.

And that's all a process. So those are the kinds of heavy things that we're thinking about. But it takes time. It takes a lot of effort and investment from the leadership, who have been great about it. It takes a lot of effort and investment from our staff. And then we're trying to also have this conversation with the national stakeholders to help them start seeing us as a different thing.

Because everyone wants the leadership, and they want the communications, and they want, you know, the other stuff that we've been trying to provide over the last 4 years, but they -- we have to help them understand that does come at a price, and it won't work if they won't accept that price as well.

So any other comments? I want to acknowledge the additional folks at the table so that we can update the folks who are on the phone.

Can we just go around quickly?

MR. PAOLO DEL VECCHIO: Sure. Good morning again, everyone. Paolo del Vecchio, Director of the Center for Mental Health Services.

MS. FRANCES M. HARDING: Good morning. Fran Harding, Director for the Center of Substance Abuse Prevention.

DR. H. WESTLEY CLARK: Good morning. Westley Clark, Director of the Center for Substance Abuse Treatment.

MR. CHARLES OLSON: Charles Olson, National Advisory Council.

MS. SUZANNE FIELDS: Suzanne Fields, senior adviser for healthcare financing.

MS. MARY FLEMING: Mary Fleming, Director of the Office of Policy, Planning, and Innovation.

MS. A. KATHRYN POWER: Kathryn Power, strategic lead for military service members, veterans, and families, and Region 1 administrator.

MS. KANA ENOMOTO: Okay. So, with that, I think we're ready to start into our conversation about SAMHSA's role in advancing integration.

Agenda Item: Council Discussion – SAMHSA's Leadership Role in an Integrated Health Environment

MS. MARY FLEMING: Good morning, everybody. It seems like we're really moving into a continuation of the discussion we were having.

Yesterday, it seemed that we got a lot of sort of specific recommendations about things that we might do to advance the role of SAMHSA and behavioral health in the integration discussion. And one of the things Suzanne and I have been tackling with -- tackling is trying to help SAMHSA understand what that means, what does that vision -- what does an integrated healthcare system look like?

What's the vision? How does -- how does SAMHSA become the leader of public health efforts to improve the behavioral health of the country? What does that look like? What's the role of specialty care? Is behavioral health a specialty provider within an integrated system?

We talked -- you've mentioned that there are several models that are working. I think we'd like to try to have a conversation with you about what that system

would look like and sort of try to get above the specific recommendations of an EHR or workforce. Suzanne, did you --

So I just really want to open the discussion up to that, and I think you started to talk about that a little bit.

MS. SUZANNE FIELDS: Just to reflect on some additional conversations that occurred yesterday, and I think the themes, Chris, Ric, that others, Henry, have been talking about this morning is we're coming to this discussion with all of you, recognizing that we are not the only ones having this discussion, that the medical, physical health field is also having this very same discussion and in some instances is far beyond where we're starting and in other instances may not be.

And so, I think for us beginning to place our discussion in the context of our partners in that medical or physical health arena having that discussion where they may be a few kind of leaps ahead of us and where we may, based on some of our work, what we know from mental health and substance use, have some things that we really need to bring to them. So I think that's also a piece of the context with this smaller group that we wanted to explore today that was just touched on yesterday.

DR. HENRY CHUNG: I'm going to use up my time as much as I can before 10:00 a.m.

First of all, I think I just have to acknowledge, you know, Dr. Gonzales and his work at NIMH. A lot of what we have traditionally thought about as, you know, integrated model stems from a lot of the work that he has supported over the years and the things that that agency has funded.

But a lot of it has been focused on the primary care arena. That is bringing behavioral health into primary care, recognizing that the patient experience of wanting that to be holistic so that practitioners in those settings are inquiring about blood pressure at the same time that they're inquiring about psychological well-being, that those are two critical elements that that sector has recognized for a long time as a real need and asked for that support and help.

But if you think about SAMHSA's sweet spot right now today, I don't truly believe that is the highest-priority sweet spot. There are other folks that have managed that area relatively well who are making very, very good strides in that arena. SAMHSA needs to be an active partner, of course.

But your sweet spot, I believe, is really all the folks who are under the care of people that you've supported through grants over the years, the CMHCs, the recovery centers, and so on. What can they say about the overall health status of the clients that they're taking care of? We all know that those folks are getting

poor access to general healthcare.

How are you holding your grantees responsible for the overall health and well-being of the folks that they're interacting with? So it's not a stretch to say that we're interested in looking at improving of health status over time, first with impressive process metrics, which we're seeing, I think, in some of the PBHCI grantees. You know, who's getting blood pressures measured? Who's getting hemoglobin A1cs done? Who's getting the recommended AHRQ preventive services done on an annual basis?

But after a couple of years of that glide path, you're going to have to say show me the data that says that these folks are actually getting better, that they're losing weight, that they are not smoking. All of those kinds of things. To me, I think that's the captive audience.

Now I'll get on the soapbox in one other area, and that's the emerging recognition that we are essentially not providing gold standard treatment for psychotic disorders in many of our CMHCs, not to mention departments of psychiatry across the country. The emerging data that shows that those who are eligible, for example, clozapine, which is the gold standard medication for patients with severe psychotic illnesses, that when we look at some of the national data -- Mark Olsen just published a landmark article on this -- that there's something like 25 percent of folks that are eligible based on meeting the definition of treatment resistance and yet less than 5 percent, 6 percent of patients who are eligible are receiving these lifesaving, possibly lifesaving medications.

That medication has its issues because it is a complex medication to handle, but no more complex than warfarin and what we've used for blood thinning for a long time. No more complex than anti-seizure medications in many instances. And the issue is that we have a treatment culture that is not quite ready to handle that type of complexity. But with integration and the way that I think many of your health centers are bringing in that kind of primary care support as they think about integrating, this is another opportunity.

And so, I would say to you as an agency that you first have to look at that part of it because everyone sees that as your core responsibility, and so I would define integration in the first year or so as success in that particular arena.

MS. MARY FLEMING: I think that's -- we hadn't -- I hadn't actually thought about the idea, first and foremost, about sort of tending to our own business. I think that's a really interesting perspective. I have -- I've been at SAMHSA for about 5 months today, actually, and came out of a community system where we grappled with these issues.

And what we frequently found was that it was, in fact, for adults, primarily adults

with really serious substance abuse and mental health disorders that the sort of integration into primary care just was not successful. And really, the reverse location was building capacity at that community level was really important.

But I think paying attention to the quality of care on the mental health treatment side is clearly an important part of that. I appreciate your comments.

Others?

DR. MARLEEN WONG: Some of the conversation that's going on about medical homes, at least in California, has to do with schools possibly being a medical home for families within a community. As the funding for wellness centers, as they're called, is being made available, there are literally hundreds of school districts in California that are bringing in this integrated care approach with physicians and nurses and behavioral health professionals onto school sites.

When I think about, go back to what Dr. Chung was saying about grantees, I'm one of those grantees with the National Child Traumatic Stress Network, and I know that in the last several years, there's been a focus on evidence-based interventions. And I can only speak about the intervention in schools that we've developed.

And I think part of integration in my mind has to do with also vertically. I mean, I think interventions often are at the secondary, tertiary level, you know, lots of randomized clinical trials and all that. But when I look at the school as a system, I'm more and more convinced that what we need to do is to modify those evidence-based interventions so that every member of a school system, of the adult members have a way of understanding, and in my case specifically child trauma, and that they are able to both assess to some extent, but also to intervene.

And so, that's sort of the direction that our work is taking now is bringing it down to teachers. What kind of intervention? Could there be a teaching-learning curriculum that delivers some, you know, inoculation, if you want to put it that way, some psychoeducation that is modified from our evidence-based intervention?

Is there something that our education aides could do who speak the languages of children in schools? Is there something that the custodian and the everybody in a school district looking at children being able to participate at some level of understanding and intervening with trauma, instead of focusing on a very clinical level where there are very few clinicians in schools.

I mean, there are some school psychologists. There are some clinical social workers. But we're never going to get enough of those to actually make an impact across a school district. And K-12 is, you know, the majority of kids, like

70 percent of the children in the United States are in K-12 schools.

So, to me, that's kind of also what integration means. It's kind of like vertical and horizontal as well.

MS. A. KATHRYN POWER: If I had to tell you that the six States in New England defined integration the same way, I would be lying. And to tell you that from the standpoint of their perception of what SAMHSA's role is, it is this. It is that we need to help them think through the basic integration of substance abuse and mental health services.

Because there's three States with separate authorities, and they're still struggling with what that means in terms of a separate substance abuse authority under a public health agency and a separate mental health authority agency. So that's the first level of integration.

Second level of integration is what are we doing about the primary care, behavioral health opportunities through certainly our grant programs, but it's going to be the issue of bringing those programs to scale. We have 100 grantees across the United States. How are we going to bring that to scale if that's the way we want to go?

And that vision is very different. That's supporting FQHCs, as well as CMHCs, as well as the sort of older infrastructure of substance abuse and mental health agencies. And we have some indirect relationship with them because that's really a State process, not a SAMHSA process in terms of supporting those agencies.

The third arena is what does integration mean in terms of the larger public health system, which really gets at where are there other sectors that we need to be interacting with that, in fact, we can bring our message about integration and the essentiality of behavioral health into that sector, which is a larger sort of umbrella approach and becoming much more of the public health message agency that we have adopted over the last several years.

So our States would say, SAMHSA, you need to help us with all of those.

MS. CASSANDRA PRICE: This is Cassandra Price.

I'm really glad to hear you say that because I brought up a lot of the same concerns yesterday about where States are with integration, how they define integration, and how it is being implemented or not implemented in a State. So a lot of times you see States have a lot of grassroots and communities and providers that are actually taking the lead and doing some really basic work and collaboration, if I can call it integration, at the real street level versus the State being kind of I'm going to push this down and inform it.

So I think it's really assessing where a State system is at all levels and supporting that and figuring out kind of what the footprint or blueprint, which I hate that word, but is to help support that work versus saying it is not as valuable because it doesn't meet this kind of criteria.

And so, I think that's been kind of my concern of kind of the general and the real gung-ho conversation of integration not being comparable to what's really happening in States, in the streets, on the field -- or in the field and valuing how it is being defined or self-defined.

So thank you.

MS. SUZANNE FIELDS: If we could separate out a bit and so the themes I'm hearing, both in terms of this discussion yesterday and a bit about SAMHSA's growth spurt and the field's growth spurt, is we have this immediate need and desire to respond to needs now. And Cassandra highlighted those today and was quite eloquent about those issues in your State and your colleagues' States yesterday.

We also have a responsibility to anticipate 5 or 10 years from now. So the challenge, and I think part of the question that Mary and I are wanting to bring to this particular group of folks today is just that. I think we can go out and be responsive and think differently, say, about our current portfolio. Henry, to your remark, we can anticipate and think about where States are and think about it as a continuum and maybe even a trajectory I think was the word I tested out on you yesterday.

But we also do have a responsibility to anticipate where the field is going to be 5 or 10 years from now, not just respond to the immediate needs or the short-term needs. And I think that's a bit where the vision is I don't want to say fuzzy, but we need to test out some of those thoughts we have about what 5 or 10 years is from now.

And I think that's part of what we were wanting to get out of yesterday's dialogue. Some of that happened. But certainly, part of this smaller group, this particular group's dialogue as well. Is it that there is going to be a parallel specialty care for behavioral health and a parallel integrated care for behavioral health? Is it that there's going to be one or the other?

How do we begin to think conceptually about how we align or think about our dollars and our spending and our partners' dollars and spending that we want to influence in that lever of influence about how those systems are going to be? Those are the types of kind of 5 or 10 year down the line issues that we're trying to even articulate what will be the questions? What could it look like, and how do we begin to anticipate that now?

MR. CHRISTOPHER R. WILKINS: Thanks for that. That's a great question.

And as you were asking it, I was thinking back to Dr. Chung. The only way that I can understand integration today or integration 5 years from now is standard of care, practice of care, standardization of metrics and outcomes, and a few other things. But let's take those three as the big three. That's the language of universal connection, right, in healthcare.

And Dr. Chung made me think about the access disparity in the addiction world to addiction medications. So there are three or four big problems with that. One is we've been in this 100-year war about the same 7 medications, more or less, and none of them are terribly widely used, I guess, save for methadone.

Second, the research investment in addiction medications has never been as robust as I'd like to see it. I went three subway stops from here or Metro stops from here last night, and I saw an NIH billboard on underage drinking. And I thought I wish they'd saved the money on the billboard and done more research on the addiction medication thing.

And then --

[Laughter.]

MR. CHRISTOPHER R. WILKINS: And then Dr. Clark has been heroic about this, as I said. But getting, getting States to align their Medicaid practices with what you all have put out there in VA and SAMHSA in terms of standard of care and the appropriate metrics, how we get that operationalized using the block grant as leverage. Not using the block grant as leverage changes everything.

When you walk into a hospital, which is what I've spent most of the last 12 years doing, to practice inside, and you sit with the chief of medicine and the chief operating officer, what are the dimensions of the patient population? What's the problem? What's the standard of care? What protocols? What quality assurance measures? What roles and responsibilities? Who's going to do what and when? How are we going to communicate? Are we going to look at the patient after the care is over to make sure they don't have another bad day?

That's the language of integration, and only the entrepreneurial part of what we've traditionally considered our field can speak it. So that's how integration has got to be structured and thought of, and policy, payment, regulation, science, and measurement have to be aligned.

DR. HENRY CHUNG: Sorry. Just to answer Suzanne's question, I mean, no one really knows for sure, but I think there are some trends that are occurring that will not go back, and I said this yesterday.

The trends towards basically larger systems beginning to take ownership over populations is, in my view, inexorable. That the market forces are such that when you begin to align payment streams and you begin to incentivize people to take care of populations and healthcare providers directly taking either full financial risk or shared financial risk that the value statement for behavioral health becomes extremely clear at that point in time.

So there's no doubt in my mind that behavioral health will be a key ingredient of managing populations, but to the earlier point that Chris made, there's a lot of lack of awareness about what the evidence-based guidelines should be and what the quality metrics should be. So people need to step into the fray and define that because, otherwise, what are they purchasing? Or what are they building? So I think that's going to happen.

The other thing I would say is that the behavioral health community that is currently configured right now, with all the separations between the substance abuse arena and mental health, those artifices are going away because they make no sense to anybody at all, including our consumers. And to the degree that any of our consumers believe that separation should occur, that's just pure indoctrination and cultural convention. It is not evidence. It is not what we ultimately want.

So I believe that many of those organizations are going to go away. Their lifespan is going to be relatively short in the same way that we're seeing small physician practices and small group physician practices go away. It's a loss, and I think that in some communities it will be preserved because that's really the only game in town, but as these populations fall onto financial risk, I think that many of them will have a difficult time and should go away, quite frankly, if they cannot adapt to modern times. But they're going to need help, and they're going to need a glide path to get there.

And finally, I would say that there is some concern that people have about healthcare providers taking financial risk on populations. You know, what does that mean? And is that going to be different from what the health plans have traditionally done, you know, give short shrift on care and things like that? There is that danger, and I think there's no question that States need to grapple with for-profit versus not-for-profit entities and other kinds of things. But my heart tells me that there will be better accountability if healthcare providers take that responsibility on.

And the reason, the simple reason is the following. Healthcare providers, by and large, don't move. They don't really care about churn because at the end of the day, they're in the community, and so this is the community they have. So we're in the Bronx at Montefiore. That's the community that we have.

Now they can have eight plans, and they can churn from plan to plan, year to year, but at the end of the day, they're still coming in through our doors, and we still have to take them. So I kind of feel like, you know, it's the right answer until we get to something like single payer. But that's my view, and I think that that's - you know, SAMHSA needs to figure out if that's going to be the future, where do you fit in.

So --

MR. PAOLO DEL VECCHIO: One thing that really struck me from Marleen's comments was the school-based wellness centers, and I think that's a great approach. I also want to just indicate about in terms of addressing an integrated approach specifically for children and youth and families, the needs, I think, for us to engage pediatricians. And how, when we look at the health home waivers that have come forward thus far, primarily adult focused. And yet systems of care approaches are really about integrating various systems together in an integrated, team-based approach.

So how can we take those kind of lessons from our systems of care, the need for family-driven, youth-guided approaches to that pediatric clinic or that pediatrician's office? I had close friends of ours, my family, whose 14-year-old going through a rough time this past fall, and the first thing they did was go to their pediatrician. I mean, it is the first stop for folks.

And I think it's a great place also to look at the prevention agenda within and things like screening and early identification and mental health promotion as well.

DR. MARLEEN WONG: Well, if I think about SAMHSA 5 or 10 years down the line and providing guidance along -- about these issues, I think about my university, which 3 years ago began a distance learning program and a very sophisticated one. I mean, you know, students click. It opens up. It's like Harry Potter or Hollywood Squares. The professor is in the middle. The students are around. There are six and eight, and they're all talking to each other. And concomitantly, we developed a telehealth clinic.

So what's the community of University of Southern California? Well, now it's 3,200 students who are in 43 States, Germany, Canada, you know, Japan, wherever there are military wives, spouses, and people. And in our telehealth clinic, we've seen thousands of people, and where are they? They're in those same places. And it's a clinic like any other clinic, but the community, the definition of a community is entirely different.

So is it going to -- I come from central California. Is it going to be like farms? Is it going to be like mega farms so that the little ones kind of disappear because economically they can't survive. And the bigger ones, well, they've got transportation. I mean, all this kind of stuff, what telehealth clinics have takes

care of the access problem.

So we have a patient in Alaska who wouldn't be able to see anybody because she's got to fly out of her community to get to Anchorage to see someone. Well, now we can see her. We literally can see her through the teleclinic.

So I think this is the future. I mean, we were the spawn of the devil among schools of social work for 3 years. You know, outrage. How can social work be taught on in a distance learning? And now 60 other schools of social work are joining in.

I think telehealth and telemedicine has already begun, and I think that's just more of a trend. And so, how do all of these concepts apply to that kind of community and community care?

DR. LAURENT S. LEHMANN: Thanks.

I've just been very fortunate working in VA for my career because we have mental health and substance abuse integrated. We have increasingly primary care engaged with mental health in our patient-aligned care teams.

But that clearly is not the case in most, if not all States. And I think that in addressing what happens with the States and looking at the communities, you need to take the standards of care, the clinical outcomes, and what works -- what is being demonstrated from that and the fiscal aspects because there are any number of publications that talk to us about engaging some ways of monitoring the physical health parameters such as hypertension, diabetes, of the community mental health center population that showed that the patients got better, that showed that they used less emergency room or hospital admissions, which are the major cost savers, and then failed as soon as the grant money went away. And it's not necessarily SAMHSA granted. It's whatever grant they got.

And so, I really think that along with the clinical outcomes and the patient response, we do need to track the cost savings and find those places where they persist in the State environments and in the community environments, whether they're State funded, whether they're nonprofits or whatever, and sort of find your champions within the legislatures to support that and keep that running at the State level. That's the sort of way to getting -- we also need to find national champions, and that's one of the things that can help reinforce SAMHSA's funding.

But the power of envy. If you see a program in one State that's really going well and consistently having savings from healthcare or better outcomes and the ways in which these work, then another State will say why can't I do that? And I think that's something that needs to be considered by SAMHSA. And then we

need to inculcate into the States as they're working to sort of track all of those things, including the financial ones, because it's a money talks kind of thing.

MS. ELIZABETH A. PATTULLO: And just to piggyback on that, I think you're correct. I think one of the questions that came up in Massachusetts very early on in our managed care, you know, explorations in the early '90s -- and Suzanne knows a lot about this -- was whether we should pay provider organizations for doing quality work, what was recognized as, you know, should you be paid extra for meeting the quality goals? Or should that be a standard contractual responsibility?

And one question that I would just ask is, you know, some of it how can we get support from the States or from other places? But how can we get the accountable care organization? How can we get the community-based provider organization to plow those savings back in to become self-sustaining in some ways if it's really good practice?

And I think part of the challenge is, you know, our collective responsibility to bring what we know to be state-of-the-art, evidence-based practice to the population at large and not to expect, as Chris Rock would say, to get a cookie for it, but to have that be a fundamental responsibility that we all carry. And you know, it's different places within States, let alone across 50 States in terms of the development.

But I think for us to kind of get excited about, again, not necessarily being rewarded, but other than we're doing the right thing and let us spread what we've learned about how to accomplish that widely and share that clinical innovation or whatever it is that has taken, and that might address some of the funding problems, if we assumed that that was part of our responsibility.

MS. FRANCES M. HARDING: If I were to look 5 to 10 years down the road, I think the part of the continuum that's going to change the most is prevention. We can't get ahead of what we're trying to do and bringing true integration without using our partners in prevention.

We have many grantees, that's what I liked Dr. Chung's comments, that are desperately trying to learn as much as they can about the Medicaid system, integration into primary care, how can we bring the talents and the science of what we've been doing in traditional prevention into being true partners with the world of treatment?

I know my great friend from the State of New York did not mean to imply that he didn't want posters and billboards. But understanding because this has been a --

[Laughter.]

MS. FRANCES M. HARDING: Chris and I have had this debate several times. But we know that in the field we often try to solve the problem within each other, taking money from one part of the continuum to feed the other.

Integration gives us a huge opportunity not to have to do that anymore, and as an example, we cannot -- if we want our society to begin to integrate with primary care, who's going to message that for you? You don't have time. Your prevention partners do have the time. They have the skill. They are the major collaborators.

Dr. Clark's staff has been working for over 2 years to develop an incredible toolkit for opiate prevention. When the toolkit was complete, we immediately partnered, and the prevention arena is now working hand-in-hand with treatment to get the toolkit out there for our communities to know what it is. We're in the hospitals. We're in the health centers. We're in the schools' nursing offices as well, and we're working in tandem with all the social workers and psychologists that we can get our hands on.

So I think that we will see the traditional prevention of substance use and mental health disorders will continue and has to continue because if we don't prevent some of these issues, like underage drinking, like prescription drug misuse, like suicide, we'll never get ahead of the game and give you the opportunity to do the treatment work.

So I would predict, not having a crystal ball, Suzanne, that you will see a change, a sea shift in the -- if we do our job right in helping our prevention field understand their great reach, that you will have partners right next to you to do the heavy lifting of messaging, of educating and bringing the environment into a different place of acceptance of behavioral health in primary care.

Sorry, Chris.

MR. CHRISTOPHER R. WILKINS: If it had been a SAMHSA billboard, I would have loved it.

[Laughter.]

MS. SUZANNE FIELDS: Are there any other comments? I didn't see any other hands. Please.

MS. KANA ENOMOTO: I'd actually like to pose a question to our youth members or others who are -- who would be able to provide some insight. You know, if we're talking about integration 10 years down the road, you guys will be the leaders when some of us have sort of cycled off and moved on to other things. You guys are going to be the leaders for the field and have some insight to the population who's going to be kind of mainstreaming and that we're talking

about 10 years from now.

So what does integration mean for that transition age youth? Paolo talked about for younger kids, certainly it means going into pediatrics and going into schools. But the young invincibles are critical to our health financing structure and security, but they're also really hard to reach. And so, what does integration -- what do you think integration means for that young population?

MR. CHARLES OLSON: I just want to say how long of a time 10 years feels to me.

[Laughter.]

MR. CHARLES OLSON: And I think that I've -- I think that I've told this story before, but when I was 10 or 11, which was about 10 years ago, I was with my primary doctor. And he's like, "I don't think you have mental health issues." I'm like, "What?" And he's just like, "Well, do you hear things?" And I'm like, "No." He's like, "Do you have hallucinations?" And I'm like, "No." And he's like, "Yeah, you don't have anything."

And that was 10 years ago. And so, you know, the odds that -- I mean, I would hope that he has been more educated since then.

But what I want to get out of that is when you're looking at prevention, you really have to stop the bleeding somewhere. And so, so when you're looking at doing training, you know, you have to -- you have to find a front end for all of this because if you don't train the doctors, who knows who they're going to miss? If you don't train teachers, who are they going to miss?

If you don't get the youth involved, these people are going to grow up to be troubled adults, and then you're going to be spending your resources trying to fix them there when you could have fixed them in the front end before they got to that point.

And just to give an example, I was noticing a lot of the suicide prevention was focusing on the middle age and the adults and things like that because that is the highest population of suicides. And that's going to continue always being the highest population of suicide unless we put some resources in the beginning where people maybe are more educated before they become adults.

So that's kind of where I would like to start with that.

MS. MEGAN GREGORY: First of all, I'm sorry I couldn't be here yesterday. I was traveling from Alaska. So I have kind of a long trip to get here.

But I used to work for Southeast Alaska Regional Health Consortium, focusing

primarily on suicide prevention. And I just recently took a position as the partnerships manager for an early childhood nonprofit in Anchorage, and so I work with partnerships around the State. And I think it's important to focus on this -- the younger children, from birth to 5, which there isn't a lot of attention in that area, instead of trying to fix these children when they're already broken and they're in high school and there aren't resource available.

I also serve on the Cooperative Extension Council through UAF in Fairbanks, and I have tried to connect some people that I know in rural Alaska because there aren't -- there isn't really suicide prevention available. It takes them hours to get to communities that have suicide prevention, and some things that they're doing is they're working with 4-H, and they're getting their children involved in that way.

And so, I think it's really important to look at those programs to see how you can align your goals and see how you can combine your resources so that you're not spending more money and you're working with these young people before there are issues. And just letting them know what resources are available because in Alaska, it's really expensive to fly from rural communities to Anchorage where primary care is. And so, that's been my focus.

MS. KANA ENOMOTO: I wonder if the council members think it would be helpful or a role for SAMHSA to flesh out a little bit more of what the various concepts of integration are?

Because some of what I have heard are integration of behavioral health into other kind of health-serving, human services, educational domain. And then there's obviously a clinical aspect to integration of what do -- what do physicians and nurses and physician's assistants know about behavioral health issues and vice versa. What do clinicians on the behavioral health side know about physical health issues? And then there's the very complex matter of financing and incentives and structures and quality.

And it feels like each of you has talked about integration, and some of you have talked about one aspect of integration. Some of you have talked about other aspects of integration, and then yet another so that when we talk about 4-H or other prevention partners, we can be including behavioral health and the other things they're doing, that when we have any kind of system, a school system, that everybody knows about the behavioral health issues, that's a different kind of vertical integration.

And then that we are getting our field informed sort of not -- or culturally competent to the healthcare system, right? So how can we be culturally competent to interact in a professional way with healthcare providers that we can speak their language and understand their values and their incentives and their constraints as well? So I don't know if you think that would be a role for

SAMHSA to play?

MS. DEE DAVIS ROTH: Yeah, I really do. One of the things I think it was Dr. Lazarus was saying in the discussion yesterday that you have a whole range of organizations that have certain capabilities and can not do things and other big organizations can. And it reminded me of life in Ohio, when I was in the mental health system there, with 300 or 400 agencies in the State. You try to introduce something that is an innovation, and you will get feedback all the way from, "Yeah, that seems good, we could do that," to "Absolutely no way, Jose. We can't do it. It's too big. We don't understand it."

And I think that some document that does that, that explains what is it that this really means that we're talking about, and how you could start. There must be some things that you can do as an organization that means you don't have to go all the way down and integrate your financing with somebody else, which you don't want to do when you're starting out. But something that would say this is what it is, but this is how one starts to get there and move along a continuum.

MS. MARY FLEMING: First of all, I was actually in Ohio at the same time working at a county when you were there, and we had a State director, Administrator Hyde, who said something that I'll sort of never forget, which was she used to tell her staff that you know you've been successful or you know ideas are catching on when you get -- when the ideas emanate from the field.

And in some respects, it feels like we're a little bit behind because the field in the States are already doing lots of things around integration. The conversation we're having here is really seems to me a struggle, reflects a struggle that Suzanne and I have had as we've tried to develop a paper, which is there's so much going on, how do we sort of begin to capture that but still vision what 5 or 10 years needs to look like? So not be bound by what's necessarily happening today, but try to figure out what we have to be working for toward in the future.

So I think, Kana, the idea of the paper, which is what we've been beginning to work on, is something we would like some more maybe discussion or feedback on. I think the issues of financing, health records, specialty care versus primary care, the relative roles, population management, and the role of behavioral health providers or systems in that are really important issues that I would see address by a paper like that.

But we also, I think, have to work with other partners in developing what that looks like, and maybe some discussion about who those other partners are would be helpful.

DR. JUNIUS J. GONZALES: I'm glad you brought that up. I was going to bring that up because, obviously, I agree with Dee. But frankly, I don't think SAMHSA should do it alone, as they say.

Having been in the Federal Government, I know all about meaningful partnership and lip service partnership with agencies, and that is a very tricky and difficult thing to maneuver. And I'm happy to say in my past life, Kathryn and I and others had meaningful partnerships, which was great and got a lot of stuff done with the institutes.

So I think it would be helpful. I mean, I was joking with Kana yesterday that, you know, the integration issue, albeit a different century now than when I started out when I moved to D.C., you know, the questions are the same. The context is different. There's a lot that's different about affordable care, but the questions are essentially all the same, and there's a lot of history, I think, to draw on.

But even from a very practical perspective, and even if it's only symbolic, I think if you want to push your agenda as well as get support for visioning for 5 to 10 years out, a very practical thing, and maybe there are bureaucratic rules against this is, you know, why are there not ex officio members from CMS and HRSA, et cetera, on this council? And because that was a strategy that the institute that I was affiliated used, and it helped pave the way to do some things.

So there are some very practical stuff, and this is my first meeting, and I know there's Administrator Hyde leads particular workgroups. But I did talk to multiple partners before coming to this first meeting, and I do think that there actually is a big interest and hunger in helping on some of these, whether it's from the science and research side or some other sides for meaningful stuff.

You know, one concrete example, again, it's always dangerous to have a tiny bit of knowledge like one objective and under one strategic initiative. But I was giving Suzanne a bit of a hard time yesterday around, you know, one metric being the broad thing of health outcomes. Well, let the other people in other agencies, et cetera, define, help you define what those health outcomes should be right from the start rather than putting something down and then sort of handing it to them.

So, anyway, I think there is a lot of opportunity. I do understand the working 70 hours a week and stretching people, et cetera. But I think everyone is so interested in and knows what high stakes integration is and can be that there really will be probably some big new partners.

The other piece, and I hope this is not anathema, is I'm also very interested, you know, sort of in terms of the engagement with there was reference made earlier to entrepreneurship, I think, from Chris and the people who are entrepreneurial. Well, there's no corporate or business entity sort of sitting here or I'm sure they're engaged in other SAMHSA activities. But that is another very powerful lever in terms of who is going to be controlling what gets done around integration.

MS. A. KATHRYN POWER: Let me add my endorsement of the notion that since integration is going to move at the local and State level, the regional administrators have worked really hard to focus on two primary areas that the States want. One, they want prevention collaboratives, and those prevention collaboratives are forming and have been forming over the last 2 years.

And one, they want collaboratives on integration, and that means that we have no conversation at the regional level or with States without having CMS, HRSA, SAMHSA, ACF at least a part of the conversation so that the regional offices of those Federal agencies are as caring and as on fire about ensuring behavioral health is a part of the change, and so I really applaud the notion that we could also do that at the Federal level in terms of sharing information. But it is absolutely going on at the regional level.

MR. CHRISTOPHER R. WILKINS: This maybe goes back to Charlie and Megan's comments. One of the futures I think we have to prepare for is -- in 5 years perhaps is a movement, a social movement by the millennials to occupy healthcare. To say you know what, you guys, your bricks, your mortar, your trillion-dollar structures, your payments, we're going to do every and anything we can to use the power of technology to work around you, leave you alone, not be consumers in your system and run our lives our way, based upon the power of those technologies and networks.

I know that sounds a bit far-fetched, and perhaps it is. But it is a scenario-planning exercise I would urge everyone to do.

MS. SUZANNE FIELDS: I just wanted to say, looking at the time and knowing that our time for this is nearing its conclusion that both Mary and I greatly appreciate your comments for today and the thoughtful discussion. Today's discussion, unlike yesterday, which focused on actionable items, we knew that what we were bringing here today could not be wrapped up in a neat little box with a pretty bow on it. But we do appreciate being able to collectively grapple with this a bit and to have your responses and your smart thoughts back for us.

So I do -- I can anticipate that this will be a further conversation that we seek out with all of you. So thank you again.

MS. KANA ENOMOTO: So we are a bit ahead of schedule, but since Kathryn is here, I think we'll just move ourselves up.

We'll have a 15-minute break, and we'll reconvene at 10:50 a.m. for our conversation about military families.

Thank you.

[Break.]

MS. KANA ENOMOTO: Okay. We are ready to start back. This is the SAMHSA National Advisory Council, and this is our session on SAMHSA and military families, which will be led by Kathryn Power, and our reactor will be Laurent Lehmann from the VA.

Agenda Item: SAMHSA and Military Families

MS. A. KATHRYN POWER: Good morning, everyone. Nice to be with you.

I put my card on your place set so you know how to get in touch with me, and I am delighted to offer an overview to you this morning on this strategic initiative.

First of all, I want to ask how many people here have ever served in the military or worn the uniform of the military?

[Show of hands.]

MS. A. KATHRYN POWER: Anyone -- Larry has? Okay.

How many of you have family members who have served in the military?

[Show of hands.]

MS. A. KATHRYN POWER: Oh, that's great. Okay. That's wonderful. And we all know people who have served in the military. So I think this, even if we don't have our own personal experience, we know that as part of the fabric of our society that this is a population that we are paying attention to here at SAMHSA, and we are going to continue to pay attention to.

My job here today is to just give you a brief overview, and after I complete that overview, Larry Lehmann, who has been our stalwart VA rep on this council and a collaborator with us, will react and make his own comments.

And I'm going to start with just a quick overview and use some policy examples. I'll talk a little bit about partnerships. I'll talk a little bit about some of the ways in which we've tried to address this population with programs, a little bit about the fact that we use policy academies as an effort to educate States and stakeholders, and then a little bit about accomplishments.

You know that this is one of SAMHSA's eight current strategic initiatives, and I will spend a few moments just telling you what makes this unique. I think every strategic initiative thinks they're unique, and we are because they're all very

different in terms of scale and scope and evolution.

This one in particular is unique for a lot of different reasons. But it is unique because the actual grouping of thinking about this population started in 2005, and what happened in 2005 is that Liz Sweet, who is a project officer inside the Center for Mental Health Services, discovered that her statewide family network grantees were coming into their discussion and into the grant offices and saying, "I'm really concerned. I have a son who isn't reintegrating well." "I'm really concerned. I have a grandfather who's upset about his World War II experiences." "I'm very concerned that my family, my daughter who's deployed is having difficulty connecting back with her children."

And we began to hear from the community providers about the fact that they felt estranged from this population and didn't quite know what to do. So the major overriding goal for the fact that SAMHSA pays attention to this is to bridge the military-civilian divide. Because the military-civilian divide is the gap where all of these issues really have arisen from because the public believes that the Department of the Defense and the VA will take care of every single individual over their lifetime for every single problem or every single life-occurring event. That's the civilian perception.

And in fact, we learn that that is not the case, and in fact, it is less of the case now, perhaps at least on the DoD side, than it has ever been. And so, when Liz brought this to our attention, we decided that we needed to bring this discussion to bear.

So we created a small workgroup inside SAMHSA, mostly comprised of individuals who themselves had served or who had family members who were serving, and that become sort of a volunteer workgroup process to start asking ourselves how can we be supportive and helpful for this population? And how can we assure that their behavioral health needs are going to be addressed appropriately?

And so, over time, that dialogue and that discussion moved forward, and you can see that in 2010, so 5 years after we started that discussion, in 2010, the new Administrator came in, following on the heels of the former Administrator sitting at the table here, who said that military families are important. And Admiral Broderick really kept that moving and kept that alive for a long period of time.

And then, when Administrator Hyde came, she said I do not want to happen to the Iraq and Afghanistan population what happened to the Vietnam population. That we will not forget these people, that we will make sure their behavioral health needs are met, that we will do whatever we can at SAMHSA to ensure that we move forward. And she established it as a formal strategic initiative, and we cited these goals.

These goals are important in the sense that it cites active duty people, members of the National Guard and members of the Reserve components, and they are really the components that we are most concerned about, frankly, because they are the ones who get detached from active duty units and go back into their local communities often without any connection with any military facility anymore. And we're concerned, of course, about veterans, and veterans were arising as a larger issue because what was happening is that we were watching the suicide rates for Vietnam veterans explode.

And so, we began to understand that we needed to articulate the fact that SAMHSA, even though we are a small agency, we had no authority, we had no appropriation, we had no staff, and we had no program. But we wanted to communicate that we cared very much about ensuring that the behavioral health needs of this population were important to us, and so these goals are very broad and they're very, I think, amenable to interpretation. But we began to understand that we had to have some conversations with our partners at DoD and VA, and we began to understand that we had to make sure we were focusing on the quality of behavioral health prevention, treatment, and recovery services.

We wanted to be sure that we were focused on resilience and tying the prevention of suicide into our prevention strategic initiative, and we wanted to be sure that we were a part of the effort. We're certainly not doing this by ourselves or not communicating with others, but that we wanted to be part of an effort to develop a seamless behavioral healthcare system for military families, and we wanted to do this through the coordination of policies, et cetera.

So how do you start this process? Well, what began to happen is that we had anecdotal interpersonal relationships. We had a relationship with Larry Lehmann, who's been on our council for years. We had a relationship with some of the staff at DoD that happened to come about in a variety of ways.

And so, once the Federal partners understood that SAMHSA had an interest in this, we began to be included in conversations, in discussions, and in opportunities to sit at the table to begin to do some planning and program development with our other very big partners. I can't tell you how big these partners are.

If you think about SAMHSA with 500 people, and you put it up against DoD and VA, we're talking mammoth partners. And so, how is SAMHSA going to have any kind of relationship when I don't have 50,000 people that I can call on, or I don't have necessarily the capacity within programs to do some of the things that we might want to do?

So we started very small, and we're still very small in the sense that these relationships are one-on-one. They are generally linear, and they're generally horizontal and vertical through the organizations. And we tried to do it in terms

of those conversations by saying we're here to help. We have some expertise, and we're here to help you, OVA and DoD and other entities, make sure that the behavioral health needs of this population are not forgotten.

And so, the ways in which we've characterized our work is through the policies, through the partnerships, and through influencing the behavioral health service system wherever we can, either at the national level or at the State level, by making it more accessible and by focusing on positive outcomes.

So some of the policy examples -- and Geretta, I have a couple of resource documents sitting there, right there where Marla's name is. There's a couple of resource documents that I'll send around that I'll be referring to, but these are documents that have been developed over time. And what began to happen is as we sat on many of these task forces, some that looked at the Walter Reed critical situation, some that looked at suicide prevention issues, some that look at emerging behavioral health issues that the Congress was concerned about, and SAMHSA began, over those years between 2005 and 2010, to be tapped to participate in those.

And the first one was the Presidential Study Directive 9, which became the Interagency Policy Council that, in turn, created the President's report Strengthening Military Families and came out in 2011. And by any -- if anyone wants any of these resources that are being passed around, we have copies if you would like them. Master Sergeant Stephanie Weaver sitting back there is the resource for those. So if you'd like a copy of any of these reports or you'd like a copy of any of these resources, please do not hesitate to ask.

So now here comes this administration, this administration saying this is a population of concern to us. So here's a President, his spouse, the Vice President, and his spouse very clearly demonstrating that this is a population that they want to focus on.

And Strengthening Military Families basically had four goals that said we're going to improve the psychological health of this population, and that was the military term at the time. We were going to make sure that spouses had appropriate career opportunities because spouses often lost their jobs when their husbands and wives were deployed. We're going to make sure that military child education is better, and we're going to make sure that military childcare is better.

So there were four specific things in the President's report. SAMHSA co-chaired the goals on psychological health improvement, and in that way, we were able to lay in front of our partners the opportunities to use policy academies, which I will talk about in a little bit.

We are currently operating under Executive Order 13625, which is the President's next iteration in saying VA, DoD, and HHS broadly will, in fact,

continue to collaborate on improving mental health and substance abuse services for veterans, military service members, and their families. This is a very significant move and a very significant amount of work.

Administrator Hyde is one of the co-chairs of the interagency task force that was created out of this executive order, and these are our marching orders. And just last week, we were informed that OMB and the Domestic Policy Council are taking some of the work that has gone on under the executive order interagency task force and are going to morph it into the performance.gov opportunity to work on opportunities and improvements for veterans mental health in the 2015 through 2018 timeframe.

So this is an interesting segue point for that kind of work, and the administration's commitment to staying on top of the needs of this population for as long as they are in power. And obviously, we continue to work with TRICARE and with DoD in ways that are actually not all that positive, but we're working forward to continue to try to have conversations with TRICARE. TRICARE is currently undergoing a pretty rigorous review to match what their current old benefit looks like and compare it to what the new parity law requires. And so, we're going to await that analysis and then move in with some conversation about what we would like to see happen in TRICARE.

Our one key partnership, of course, is with the VA, and all of that is rooted, and I know you all know very much about what we've been doing in preventing suicide, under the prevention strategic initiative. The information about veteran suicide is just overwhelming, and we want to continue to focus on making sure that that partnership exists.

We have multiple MOUs with the VA across a variety of service sectors, but most particularly, it is our 1-800-273-TALK line. We support the infrastructure of the 150 crisis centers across the United States, and in fact, we continue to work very, very closely. Richard McKeon, Eileen Zeller, tremendous CMHS staff that do an enormous amount of work in collaboration with VA.

We have expanded this line throughout CONUS in multiple other continents and across the foreign countries, and there is a chat service. There is texting and, in fact, we have exchanged protocols and evidence-based practices around prevention with VA, and they have adopted many of our protocols. And it's really a wonderful working partnership that continues even as we speak.

We also have other partnerships that generally have developed into MOUs, statements that say we'll support you in looking at military mental health, and we'll support you as well. And so, we have an FTE that is on -- given to us from the National Guard Bureau. That's Master Sergeant Stephanie Weaver.

She has been with us for 3 years, and we have been very fortunate to have her

inside SAMHSA as our liaison to not only talk about counterdrug programs, and she came out of the counterdrug environment in California, but has morphed into a person that knows everything about SAMHSA and can talk about our programs, can talk about our issues, and represent both the Administrator and myself brilliantly when she has to.

And so, we're very lucky that Master Sergeant Weaver has been with us and really, I think, is the core reason why we've been able to do what we've been able to do because the National Guard were hungry for having partnerships with agencies like SAMHSA. And we used the National Guard relationship to kind of model what we could do with other sectors, what we could do with other entities, and it really has served very well.

We will lose Stephanie in July of this year. She will be retiring, and we're going to have a massive party here for her. So you're all invited. And when that happens, we lose that capacity. And so, part of that issue is that we have to transition now in terms of looking at how we shape the future of where we go with this population in terms of SAMHSA's commitment.

We had an MOU that Dr. Broderick was a part of in terms of ensuring that one of our staff whose spouse was deployed, was based in California, then was going to be deployed, she was able to take her project director work and work as a project officer outside of the California base and was just a tremendous asset. It was actually goal three of the President's report Strengthening Military Families that we do that and we model that in terms of she not having to leave her job at SAMHSA. It was a great opportunity for us to show that.

And then we had an interagency agreement with HRSA where we were able to encourage their AHECs, which are their area health education centers, and to train the individuals who work in HRSA FQHCs and community health centers and, in fact, train them in military culture, what we call "Military Culture 101."

And so, getting civilian behavioral health and healthcare workers inside those health centers, beginning to get them comfortable about talking about the experiences of military families, what are some of the issues that military families may bring to the health centers, et cetera.

Now how -- those were sort of policy and partnerships. The other ways in which we've worked is to try to influence the behavioral health system, and we're very lucky at SAMHSA that we could begin to inculcate the priority of this population into some of our programs, and that was really the way we got a foothold.

And CSAT's Access to Recovery program was the first out of the gate. They were the first ones to say, yes, we have a voucher program. We think that this is a population that we can reach through this voucher program and through the grantees. And 24 of their 30 grantees have over time made this population a

priority population, and it's been a tremendous, tremendous effort.

And frankly, you know, Master Sergeant Stephanie Weaver was key in making sure that the National Guard knew about this thing because, remember, National Guards are State specific, and we have to connect them with the ATR grantees that are in various locations. And we have really moved that, and it's been a really wonderful success.

The second out of the gate was the CMHS jail diversion and trauma recovery priority to veterans. That was, in fact, a program where the efforts were to make sure that justice-involved veterans with PTSD and trauma-related disorders were given appropriate care and treatment within that grant program.

We also have created -- with a little bit of block grant money, we have created a service members, veterans, and their families technical assistance center. That technical assistance center is available to work with the States who have gone through the policy academy and who have developed strategic plans to make sure that they address the issues of their population.

So the policy academies became the vehicle, frankly, and the only vehicle that SAMHSA had to be able to express publicly our commitment to this population. And we gathered together a set of partners who we meet with regularly. DoD, the National Guard Bureau, VA, the National Council, NASMHPD, and NASADAD all sit on a partners advisory committee, and they help guide us in terms of preparing the policy academy experience.

So the goal for the policy academy was for States and territories to develop their behavioral health system and to understand what that population looked like in their State. So we asked -- we invited States to come to a 2 1/2 day event, usually 10 members appointed by the Governor, and they came together generally in Baltimore or in Washington. And we put them through a very intense strategic development.

We've conducted many policy academies, I think seven total in number, starting in 2008 through '10, '11, '12, and '13. At the end of that process, 46 States have participated, and D.C. and 4 territories. We, through the technical assistance center, provide them follow-up, and we generally had four States that decided for political reasons they did not want to join in at this time in a policy academy.

And so, we feel like that effort has really been now started and implemented and is moving forward. The irony is we went back -- we had no money, by the way. We used carryover money in 2008, 2010. 2011, DoD was able to provide us some Yellow Ribbon campaign money in 2011, and then we've got an appropriation the next year in terms of being able to operate several 2012 and 2013 policy academies. And that appropriation is not in the 2015 budget.

So we feel like we've gone through this first level of effort, gotten the States mobilized. They have their teams, et cetera. We went back to the 2008 teams, last -- about 3 months ago and said are you still working? Are you still there? Are you still caring about this population? And all those States were still working, still intact, still moving.

They're all volunteers. They get no money. I mean, they're just doing this because it's the right thing to do. And so, that meant that I think we had incorporated and inculcated a sense of responsibility and that picked up the notion that these States really do see this as a long-term commitment.

And so, here's the picture of the policy academy States. You can see those that have moved. We're very, very fortunate that the States who have mobilized, even the States who haven't been in a policy academy are actually doing things with this population. So it's not that they're not doing anything, but that this has been -- this is the layout of over the years the policy academy attendance.

Now I'm going to talk for a little bit about some broad accomplishments on the strategic initiative, and I think it's important that you know that these are -- again, there is no program that does this. There is no cadre of staff that do this. And these are one-on-one relationships that we have with various component parts.

The Administrator has a one-on-one relationship with her co-chairs of the interagency task force. You know, I have a one-on-one relationship with particular people at DoD and VA. Stephanie has one-on-one relationships with various component parts. And this is all very much related to our belief that we need to be visible. We need to be out in front. We need to be saying SAMHSA has resources. We need to be talking about military culture training. We need to be talking about the military-civilian divide.

We have to get over this notion that DoD and VA will be able to do all of this. They can't. People are in the community now. People are returning to the community. Only about 40 percent -- and Larry, you can tell me if this is right. Only about 40 percent of the people who are eligible for VA services are using VA services. Sixty percent are not.

Our job is to help them get to VA services as appropriate and refer them appropriately. Our job is to make sure that the community providers know about what's available. Our job is to make sure that if they're not eligible for VA services that our community providers feel comfortable and confident and competent to be able to provide services. And I think that that's all part of what we have to continue to do.

We have worked really, really hard to get DoD and VA to not use the word "stigma." We're crawling our way to the top of the mountain to say every time you use that word, you restigmatize people. It's considered a mark of shame,

and you have got to figure out other words that -- oh, by the way, here are other words to use. Discrimination, isolation, prejudice, loss, all of those. And so, we're working very hard to make sure that happens.

And Stephanie and I were looking at a document yesterday. How many times did "stigma" show up? Seven times in the document. So we get on the phone, we say, "No, no, no, this is the way we're going to frame it is this." And so, we need to -- that's part of our messaging and part of the work that we have to do.

We have, in fact, worked with the national council to make sure that we're sharing a lot of information about cultural competency training and making sure that all the work that we've done in terms of military families is now up on the SAMHSA intranet so that incoming staff can learn about the fact that it is an important priority population.

One of the other programs that is specifically looking at this population is, of course, the National Child Traumatic Stress Network out of CMHS. They fund a host of academic centers and therapeutic service centers, and they have a focus on military and veterans and families. And they do a tremendous amount of work. I'm not going to go into each slide here. You have this in front of you.

But there's a tremendous amount of work derivative of that grant program that has really focused on not just the trauma of the individual service member, but the effects of trauma, the effects of traumatic environments for military children. And we have, in fact, also looked at making sure that the military families and veteran families are connected to many of the products. There's many products that the NCTSN folks put out.

The other area, the other program derivative of work out of CSAT has been the Screening, Brief Intervention, and Referral to Treatment. We are having enormous success between connecting the SBIRT program and many of the National Guard programs. So CSAT took the lead working with Iowa, and they have, in fact, created some documents and some resource materials that are available for other National Guard components across other States.

We have -- and again, this is -- I'm trying to show you this because it sort of works in an anecdotal nonprogrammatic way. Someone talks to someone. Someone says do you know what Tennessee is doing? Stephanie talks to the TAG. We get them connected over here, and so we're always trying to connect the dots in terms of making sure that these -- that our programs that appropriately would fit into their work would be connected.

So we see SBIRT and the connection with the National Guard growing enormously over the next several years as the TA center pushes out that opportunity and as the National Guard units see that as an opportunity and as the SBIRT staff -- and we now have an SBIRT ATTC. So that SBIRT ATTC is

helping guide that conversation as well.

So there are component parts across all of SAMHSA's portfolio that, hopefully, we will continue to move forward. Here is again New York, and we're going to be meeting with the National Guard bureau and particularly to talk about SBIRT. And in this case, they would like to see an SBIRT for mental health.

Is that correct, Stephanie? I think Admiral Hunter wants to start looking at SBIRT that not only looks at substance abuse, but also looks at mental health issues. And so, we're going to have that conversation.

All right. The way forward. That's a military term, by the way, "the way forward." And we always talk about what's the way forward? So what I am doing in 2014 is I'm having conversations with all of the strategic initiative leads and asking them what do they think about where we might go in the future from their perspective?

So I've met with Dr. Clark. I've met with Paolo. I've met with Fran. I met with all of the folks who had the leads, and we are having those conversations about so what do you think we can do in terms of embedding this population into the groundwater of SAMHSA? It will not be a strategic initiative next year. We have no appropriation. We have no -- et cetera.

We're going to put it into the groundwater, like we do with tribes, like we do with other populations, and we're going to make sure that to the extent possible, our next six strategic initiatives will focus on this population. And we will not only do that, we will look across the RFA portfolio, the contract portfolio, and ensure that many of these population needs can go forward or that we will specialize by saying we want you to pay particular attention to this population in the RFA language.

So I'm having very fruitful conversations with the SI leads, and my two questions are can you bring SI -- can you bring this population and in what manner could you do that? And are there additional suggestions that you have?

So I've been very fortunate to have rich conversations. I'm compiling all of those ideas. Many of them are very practical, very worthwhile, very appropriate. And some of them come from not only who they are as the SI lead, but who they are as the center director. And so, they may take a response and say, oh, no, I think we can do military population in the prevention side.

So Fran will talk with ONDCP and talk with other folks about what they're doing, and we can kind of move that conversation forward. And then Dr. Clark had some ideas about what the CSAT portfolio was and then, distinctively, some ideas about HIT and what we might think about in the military populations for HIT.

So I think those conversations have been very, very rich and very, very worthwhile. And that's what I'm going to do for 2014, report to the Administrator on those findings, and we will move this strategic initiative into becoming a priority focus area for SAMHSA for 2015 through 2018, and that's what you'll see in the Leading Change 2.0 document when it becomes finalized.

So, with that, I'm going to stop and let me just add I do have some resources here in case you're interested about getting connected or you want to get connected with some of the resources. You have my phone number on my card. I will continue to be the strategic lead through 2014. And as a matter of fact, I'm leaving shortly to go to North Carolina to do a speech at North Carolina Healthcare Systems all on this population.

North Carolina has one of the largest military populations in the United States, and so I'm going there to talk about what SAMHSA is doing and, hopefully, they're going to take forward. And here's Carolina Healthcare Systems that has like 42 hospitals. They want this population to be a priority, and I think that's the kind of thing that we want to continue to encourage. We want to make sure that these individuals who have served our country get the care they need when they need it and as soon as they need it.

So thank you very much.

I'm going to turn now to Larry Lehmann, who is my VA counterpart, and ask for Larry's comments.

DR. LAURENT S. LEHMANN: Thank you very much.

One of the things I'm going to say right off the bat is to pick up on the issue of the veterans crisis line and to thank SAMHSA, who invited us and let us use that system to create the veterans crisis line, use you all's existing system. And when you press 1 on the phone, the first thing is to say, you know, are you calling about a veteran?

And this has grown. There have been great leaders inside VA -- Dr. Ira Katz, Dr. Jan Kemp -- who have looked and worked at this program tremendously.

So it's -- it's really thanks to you guys that you're doing this, and we very, very much appreciate it.

The second thing is to talk about the policy academies, again a tremendous innovation. You know, it is 40 percent of eligible veterans using VA. I can tell you that overall it may be somewhat less, but for the OEF/OIF/OND population, for the folks from the wars in Iraq and Afghanistan, yes, it is 40 percent. Actually, it is somewhat higher than 40 percent using our services. A stark contrast to

what happened with the Vietnam generation folks when they were coming back.

There has been much more willingness to come to VA, and I think that's a lot because of how DoD has been more open to mental health services, which is a tremendous turnaround on their part. We actually think from their surgeons general down through the field and conferencing, for example, for their lieutenants, captains, and senior master sergeants.

And anyone who's been in the service, you know it's the master sergeants who are -- who run the show. And the officers are there just to say let's try to do this and providing some expertise in some areas.

So that's been a tremendous turnaround. But you guys again at SAMHSA have really helped to bring this together through the policy academies. And I've been fortunate enough to participate in most of those from 2008 along with other VA colleagues, and it's fascinating to see the evolution of these things.

First, they were saying, you know, what are veterans? What is mental health? What is PTSD? Where do you find where the veterans live? And how it's evolved to the implementation academy that happened in just I guess it was the early part of March to sit at the tables and see how these folks from the States who are very savvy at working their healthcare systems and their legislatures and the Governors to support their initiatives.

And these initiatives have moved from beyond the OEF/OIF population to all eras of veterans. They've moved behind the returning veterans to look for the families and the children and their services. So all the range of gender and generational issues are being touched and affected by the policy academies.

And as well, issues of the tribes. I'm on the VA Indian Health Service PTSD workgroup, and the tribes are paid attention to with these policy academies. They have tribal representatives from a number of the States, and in fact, in September, I guess 2 years ago, there was this ad hoc meeting of tribal representatives.

So those are some of the things that I think you all have done that we've very much appreciated and look forward to seeing.

MS. KANA ENOMOTO: Dr. Lehmann, I'm sorry to interrupt you. I know Dr. Clark needs to leave, but he had wanted to make a comment. So if I could let -- I know that Dr. Clark wanted to make a comment, but he has to leave. So I wonder if I could interrupt you to let Dr. Clark comment, and then we'll -- if you could conclude.

Thank you.

DR. LAURENT S. LEHMANN: Okay.

DR. H. WESTLEY CLARK: Sorry, Larry.

[Laughter.]

DR. LAURENT S. LEHMANN: Anything for Wes. From VA, you know, I mean, come on.

DR. H. WESTLEY CLARK: I just wanted to acknowledge Linda Fulton and the ATR team. We've seen 15,573 veterans in the ATR portfolio, and that's an important point is that we are quantifying the veterans that we're seeing, in addition to the over almost 7,000 veterans we see in Reed Forman's -- in his group, also from CSAT's SBIRT team.

And then, finally, you're going to be going to North Carolina. Our technology assisted care HIT team has funded in East Carolina University a telemedicine program that is designed to see veterans in rural areas. They've already outfitted a van that we helped purchase, and they've got satellite access. And using telepsychiatry, they'll be able to do assessments.

So that demonstrates that you can focus on veterans from multiple platforms. Our SBIRT, our ATR, and our technology -- health information technology programs are all trying to make sure that veterans are seen as an integral part of what it is that we do.

And the data to show that we're actually accomplishing it. So, which is another important thing that SAMHSA is doing is we moved to a common data platform to be able to cite the numbers because the numbers are, in the end, people want to say, "Did you see anybody?" And the answer is yes.

DR. LAURENT S. LEHMANN: Thanks, Wes.

Just a few more things that I want to touch base on. You are looking at where is SAMHSA going and what's happening with the issues of and what will happen with the issues for veterans and their family members as you evolve? We're looking at this, too, within VA in terms of what are the lessons learned from these war years and how we've worked together?

And there are a number that include the personal relationships and the structural relationships between mental health services, rehabilitation services, and primary care and the postdeployment integrated care initiatives that we have worked at. The consensus conferences that we've held related to PTSD and substance use disorder and PTSD, TBI, and pain that have shown that our joint VA/DoD clinical practice guidelines can be applied to veterans with mild TBI and PTSD in terms of concurrent treatment approaches rather than saying you've got to treat the

PTSD first or the substance abuse first before you can do the other.

You actually can do these things concurrently, using evidence-based practices. You have to modify things. You have to be cautious about, you know, added trials of learning for the evidence-based psychotherapies, for example. But it can be done, and we need and we are looking to ways to preserve that learning.

As you evolve to having a focus on military families and veterans across your different new initiatives, my advice to you and my plea to you is to watch that like a hawk because there are so many competing pressures and pulls of different groups who need these services and who all deserve the services. But really, you've got to watch it. And it doesn't matter what group you're in, you know?

Even within VA, there are about a third of the facilities that will readily -- everybody is going to do what they're required to do. There is a third of folks that will do really, really, really more. And a third of folks who will do what they've got to do because of all their competing demands, and a third who will do -- who will have a mixture of those things. But that's true for every single entity that there is. So that is something to watch.

We are going to, again, continue to focus on mental health summits that began this last year with community providers and with National Guard and with the tribes. We're going to continue to focus on our telehealth activities and developing online and mobile app resources, often collaboratively with DoD.

And in fact, I provided a list of those at the policy academies that are on the Web site for the substance abuse and mental health, the service members, families, and veterans sites. All of these things are available to help veterans and families support themselves as they're working in treatment.

That actually is all the points that I think I wanted to hit, and again, what I want to do here is to be useful for you and see what kind of questions you have, issues that I haven't raised, or things that you'd just like to ask.

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

And let me just add that we're here to answer your comments and questions and your ideas about what we might do. And I actually had a conversation with Larry just before I started, and he suggested that DoD ought to sit on this council, which I thought, you know, that's not a bad idea either.

So we'll go to questions or comments.

DR. LAURENT S. LEHMANN: There was an ex officio for DoD in the past, I think. I don't know what happened with that.

MS. ELIZABETH A. PATTULLO: Well, thanks very much for this presentation, and I would love, actually, to get a copy of the materials that you handed out. That would be great, if possible.

But I have a question, and Kana, you sort of answered this before. But why -- I understand there is not a designated appropriation that has the military families name on this, but why do we drop the name from our strategic initiatives? That actually came up in conversation several times yesterday, and I don't get it.

I mean, it seems to me that for all kinds of reasons -- and you've articulated them rather clearly this morning -- collectively, we do have kind of a continuing responsibility that I think Charles and Megan are going to, you know, inherit for this generation particularly of active duty soldiers.

MS. A. KATHRYN POWER: You know, I think it's an interesting point because those of us who worked at SAMHSA before we had strategic initiatives would have said we know basically where the priorities are and where the priority populations are. We had the same discussion about children. You know, why aren't children a part of the strategic initiatives?

And so, for us, it -- to me, it's not a visibility issue. It's sort of a tactical short-term issue in terms of what we talked about earlier this morning about just how much we can reach, and where can we stretch and what else can we take on? I'm hoping that the document Leading Change 2.0 will, in fact, emphasize that it is a priority population.

But in the public eye, somehow the equation of it being a strategic initiative means something more perhaps than the fact that people may assume we won't be giving it attention, but we're trying to reassure people that we are going to give it attention. And in many ways, we hope that it will be more profound because of the things that Dr. Clark talked about in terms of as we get it into each of our programs, the issue will be making sure we know that that's what's happening within those programs, recording it, making sure we get the impact out, making we analyze the outcomes and that we let people know what that's what's happening.

And I think that really then we take on all the elements of why it makes a strategic initiative in people's minds. That's my assessment. Kana, you may have something else.

MS. KANA ENOMOTO: I think the way we use the strategic initiatives is really as a management tool. We have weekly, sort of quarterly meetings, briefings on what's the movement? What are the activities? What are the grants, contracts, you know, policy activities in that particular domain?

And I think we have achieved many of our objectives that we set out for

ourselves in the three strategic initiatives that are rotating off or graduating, and so in terms of how much of the Administrator's time, for example, that we need, I mean, she actually spends personally a lot of time on military families. But I think what she felt like before when we didn't have workforce as an SI was that HRSA was really seen as the workforce lead for HHS.

SAMHSA didn't have a big appropriation, and people were looking to HRSA to lead that effort. That changed as we've had Now is the Time and an infusion of funds in that SAMHSA's role in that becomes more prominent, and so we need to monitor that as a policy priority as an executive team.

Military families, I think we did have a small appropriation and an active role. We continue to have an active role. She's co-chair. She leads for the department on military families issues. Kathryn is everywhere.

But it is clearly a leap by VA and DoD to meet the behavioral health needs of these populations, and I think we are recognizing that, and SAMHSA continues to have an expert role, an advisory role, and a nudging role. But we're not the -- what is it, the captains of that ship, per se. And so, I think that's some of the rationale for that falling off as an SI.

I mean, we continue to have it as a priority population, as we do tribes, as we do HIV, as we do everything else that we have in our portfolio. So it doesn't mean it goes away. But from a strategy point of view, I think we can rest assured that there are others at the VA, DoD, National Guard, and elsewhere that are really owning this, moving it, joining forces, first lady's office. They are on it.

MS. A. KATHRYN POWER: I think the other element of this is that I feel like sort of we christened the ship, you know, and we launched the ship. And the States now are responsible because we said we want the States to understand locally and across the State what are you doing for this population? So we've launched that through the policy academies.

And as Larry indicated, every time we bring the States together -- and we're bringing them together, by the way, multiple times this year in three implementation academies. So every single State we will see again this year, they each get a chance to send four or five people on a contingent, to talk about specific topics like suicide prevention, military families, criminal justice interaction, et cetera.

We now want them to take it as a strategic initiative, and that's the beauty, I think, of what we've done is that we were able to take it from a Federal/national strategic initiative and now bring it to the level where the States own it. And then we are there, helping the States. They all have TAGs. They all have National Guard bureaus. They all have Department of Veterans Affairs. They all have VA components. They all have active duty assets, except for Minnesota, a

couple other States.

They all have, you know, the various pieces that all have to work to make sure that those people get behavioral health services. So, in my mind, that's what we've done. We've launched it at the national level, and now the States are in control and responsible for making sure that those services -- and that's the way, I hope, that we'll articulate it with people so that the regional administrators will articulate it that way and we will all join in that vision of it, not going away, not diminishing, actually growing through making sure that it's in every place that it should be.

DR. ERIC B. BRODERICK: First of all, I want to thank Kathryn. This is an example, a case study I guess is what you could say, of the conundrum that we talked about earlier is no money, no programming, but a will. And Kathryn was that will, largely.

And this town is really rank conscious, for one thing, and it's pretty stovepiped. So Kathryn calls me one day, and she says could you be on like a little thing that they're having downtown on mental health and the military panel? And I said sure. And I show up, and -- well, I knew ahead of time, she told me -- but Secretary Shinseki and Secretary Gates and me, you know? It's just like this doesn't happen. I mean, this does not happen.

And we're talking about PTSD, and it's pretty unusual in this town for another Secretary, Secretary Sebelius ordinarily would have done that. But they looked to SAMHSA for that, and that was unusual.

And the other thing is so she said something very poignant that has to do with how to beat the stovepipe thing that exists here. I mean, the agencies are made of people, but the stovepipes are pretty -- pretty strong. And the fact that Master Sergeant Weaver is sitting here and the fact that there are all these personal relationships got established, that will do us a lot towards sort of continuing the emphasis because those won't go away.

But I think the needle has moved. Our role was -- we can't take all the credit by any means. The VA and DoD did a huge amount, but we helped nudge that policy needle. So how to sort of get it into the groundwater, I think you heard Dr. Clark talk about the data from ATR, just that becomes a part of what SAMHSA does.

And so, I know there is a need to be vigilant, Larry, and I know that we will be, but I think it's a success story. And it came at a cost. I mean, Kathryn, like Kana said, was everywhere, is everywhere. And when she was doing that, she wasn't doing something else. But it was important, and it's a part of that case study that describes how it became sort of part of what SAMHSA does.

So I'm not concerned that it's not a part of the next strategic plan because I've got confidence that it is sort of becoming part of an expectation, if you will, for our grant programs and those relationships through the Administrator and others. As long as those personal relationships are maintained -- I know the stovepipes will remain, but you can breach the stovepipes sort of one person at a time.

So thanks, Kathryn.

MR. CHARLES OLSON: I just want to say that three of my closest friends are military members, and so this is very high up on my list of things that I'm passionate about. And I want to thank you guys. I can tell that you're very passionate about it. You made a program work with very little money.

If I could offer advice, you know, you mentioned that a couple things about the VA and the DoD, the public opinion, and that might be something that you'd want to or someone should address is that I consider myself to be, as part of the civilians goes, a very educated civilian. I mean, I know your guys' acronyms. I know the terms. I've been to ceremonies. I've heard the horror stories.

And so, I would feel that even me, as an educated civilian, on what the VA does would be incorrect. And I would even think that a lot of the soldiers and military members are not accurate on what they think the VA does. And I think that results in a lot of bad press, and I think it -- the VA gets maybe overloaded with things that they shouldn't be responsible for, that they don't handle.

And in Minnesota, the public opinion of VA is split right down the middle. There is people that think it's pretty poorly put together, and there are some people that think they're doing a really good job. And I've heard stories to support both sides. So I would really -- I'd really encourage you to create some kind of a campaign or something where maybe people knew better what those organizations are supposed to be doing, and I think it would save you guys lots of time in the end and better press. I think you'd be able to serve the military members better.

DR. LAURENT S. LEHMANN: Thank you very much for that.

There has been a lot of limitation to what VA can do about publicizing itself. So it's not advertising, but we're getting increasing smarts about this and reaching out online and on the Web and in social media. Maketheconnection.net is one of those entities. Notice it's a dot-net, not a dot-gov entity that talks about service members of all eras, of all ethnicities, of all genders, and how they had mental health problems and how they were helped through VA.

So we're trying to do this, but you have to balance -- you have to balance the bad news anecdotes with the good news stories. Brigadier General Loree Sutton, who was the head of Defense Center of Excellence for PTSD and Traumatic

Brain Injury -- for Mental Health and Traumatic Brain Injury would always talk about these "good news stories." And we've got to try to emphasize those for those who will listen.

It's a significant generational thing. When I was your age, every doc or dentist that I had had, had been in the service in some way. But that's changed now as our military is smaller, more efficient, fewer people at risk. So it's something that we have to think about and factor into our thinking in the future.

MS. DEE DAVIS ROTH: This is really wonderful work, and I am stunned at how wonderful these materials are. I have a connection to this. I spent the first 20 years of my life as what is known as an "Air Force brat" and my -- I mean, kids weren't expected to have any issues, you know, back then because your father was in the military, and you were there to support him and you didn't act up or act out or any of that stuff.

We were stationed in Germany when I was a junior in high school, and so when we got to Ramstein, they had this big, you know, orientation in the base theater for all the new families. And they were in the midst of doing all their stuff, and they said, well, now if there's a war -- this was the Cold War era, and so if there was a war was like on everybody's mind right here. If there's a war, the people that are at Ramstein Air Base will be taken out, you know, the south route to go to whatever.

The high school kids that are in high school in Kaiserslautern, in the American high school which was going to, will be taken out the east route and go, hide wherever. And I realized in that second that if there was a war, I would be separated from my parents. And that happened, I hate to admit this, more than 50 years ago, but I remember exactly how I felt and exactly how it was a stress for me. And I didn't hear anything the rest of the presentation.

I think kids, don't forget the kids in all this. I was looking to see if I could find references to kids having issues, but this stuff is great.

MS. A. KATHRYN POWER: We just had an implementation academy on military families and because so many of the States said we're not quite sure what to do because the military families are really invisible. They're invisible, and even certainly they don't live on bases not anywhere near like they used to at the rate that they did. And even at that rate, you didn't have a lot of families on bases.

And they're in the schools, you know, they're in a variety of different sectors, and people do not know where they are. And that's particularly true of individual families who get off of active duty, go back to another community and are separated from all the active duty supports and services, and are not necessarily connected to any other entity. They may or may not even -- my father never

used the VA. That was his choice. Thirty years in active duty, he stepped into Medicare. And so, never used the VA.

So you've got all of that kind of different makeup of military families. So we did start that conversation with the States about, all right, how are you going to find these military families? What are you going to do strategically to reach out to make sure that you understand what is happening with those families? And oh, by the way, we want to celebrate the fact that most military families are very resilient, you know, very -- very competent, very capable.

There are stressors, there are things that happen, and not get overwhelmed with some of the negative statistics that we see about military families. But that be ready on a behavioral health level to ensure that get ready, folks, we're going to have another wave here -- with the ending of the prosecution of the war, we're going to have wave where the military is going to downsize tremendously. I mean, the numbers are unbelievable, never mind sequester.

So they're going to downsize significantly. We're going to go into a generation that will have a very different experience now. And so, we have to be watchful about what's going to happen with those that get off active duty -- homelessness, employment, all of those issues related to affecting their behavioral health.

So we're going to go through another kind of look at how the military family is going to change again. And so, we're challenging those policy academy teams to really look very carefully at asking people, you know, if they've had military duty, if they've ever worn the uniform, asking people, going into schools, asking people and identifying where those families are because, generally, they are invisible.

So that's an important sort of next generational issue, and thank you for raising the families issues.

DR. MARLEEN WONG: I've been PI, a co-PI on a grant, one with the Army and one with DoDEA and focused on the building capacity of military families, focusing on, you know, coping skills, resilience, and all that. I just wanted to share with you and ask you what we should do about a couple of things.

One is there really isn't that much support for students returning from the Afghanistan war for education. So we have many of them in our community colleges, and they succeed or fail on their own. But there isn't anyone there to say this is -- I mean, these materials are fabulous, but they speak exactly to the experience that they have.

So our school has attempted -- we have a military social work program. We've attempted to, we're trying to build in a program where our second-year graduate students can serve in that role, and we have many, many of them who are young

men and women returning from Afghanistan. Some are spouses, and some are wounded warriors.

The other thing we've tried to do is we have this large number of students who want -- their mission has not changed. They still want to serve. So, as you know in many of the schools of social work and psychology, there is a practicum, an internship. Our second-year students can't get into the VA. They cannot get into the VA even if their supervisor, the people are willing to supervise them.

You know, they have licensure, and they say, yes, we want them. They can't in to do it, and it's almost community by community. So if they know someone who's a professor in our school, they say yes. And because I think there's been some opening since the Rand report that, yes, we need to build capacity for service providers. But it's been a very rocky road along that, and I don't know if you have some advice about how we should proceed?

MS. A. KATHRYN POWER: Marleen, are you in California?

DR. MARLEEN WONG: I am.

MS. A. KATHRYN POWER: Okay. Because I'm going to head right to the State sort of issue because I think we can better make those connections at the State level, and I'm sure Larry will have something to say about the VA because we have had this conversation with both DoD and VA about how do we get people into the lines of work in terms of their credentialing process and their internship process? So I know VA is looking at that.

And sometimes that there are some insurmountable barriers, but we're actually going to look at that as a workforce issue under the interagency task force, and so Anne Herron, as the workforce strategic initiative lead, and I will be talking about how do we -- how do we stop or how do we build the capacity in behavioral health across those three departments -- HHS, VA, DoD -- using the kinds of programs that you have?

I'm going to connect you with the folks on the California policy academy team because a couple of the States, and I think California is one of them, have talked about trying to reach to the veteran population and the military population through the community colleges. And in fact, that would be a great place for you to just start having a conversation, and I talked to John Perez about some of the University of California campuses. I've talked to -- but you could talk to the team members who have an interest in the education sector and be in line then with what California has in terms of their strategic plan for this population.

So I will make that happen, and I think that would be a great place to start because I think you're right on target as to how you should be gaining opportunities for these people. But sometimes these barriers just have to be

negotiated, as Ric says, one-on-one and one person to another saying this is a good thing to do. Can you think about ways in which we might think about looking at this differently?

So, I don't know, Larry, if you want to add anything about the VA training stuff?

DR. LAURENT S. LEHMANN: Two things. One, with regard to college students in general, VA has a program for counseling on campuses where VA staff go there and work with veterans who are in colleges, community colleges, and universities because these guys and gals are older than your average college students because they were overseas getting shot at while everybody else was going from high school and going into college.

So there is increasingly, and I know that there are several sites in California that are engaged with this, and I will check with the guy who coordinates this for us is Derek Blumke, he himself a veteran. And --

DR. MARLEEN WONG: Our school is in 43 States. So we've been trying to approach this, and it's so uneven. I mean, that's the -- it's not only uneven in the State, it's uneven among the States.

DR. LAURENT S. LEHMANN: Yeah, it is uneven. Yeah, and I will check with our social work -- yeah, I will check with our social work services to see what we could find out about that. But you're more on target with this because if this is, again, one of these State things where you can get schools to do it and see what you can do to get them involved.

MS. A. KATHRYN POWER: And we sometimes hear, oh, you know, the VA won't let us do that, and then we'll go, well, who did you talk to at the VA? Well, it's this one VA that doesn't do something, and another VA does do something. And it's so idiosyncratic, and that's part of the dilemma when you have such a humongous bureaucracy that there is idiosyncratic ways.

But you can, in fact, I think, through will and passion and movement forward, you have a lot of good leadership in the VA that are willing. Now that these community summits are going on, the expectation from the VA leadership is that those community summits will open these kinds of doors, and that's the expectation. So --

MS. KANA ENOMOTO: I just want to check in if any of the members who haven't yet weighed in have any comment?

MS. ELIZABETH A. PATTULLO: Can you just maybe, Larry, comment a little bit on waiting lists for VA services?

DR. LAURENT S. LEHMANN: I don't have data on overall numbers of folks on

waiting lists, but what I can tell you is that there is a requirement for folks, let's say someone is on a waiting list for a residential treatment program that, depending on their urgency, you might try to find a residential treatment program in another area that they would feel comfortable in going to.

But regardless of that, we have to have some kind of contact, maintain some kind of contact with a person who is on any kind of a wait list for services. Usually this is for residential types of services rather than acute inpatient care or outpatient services. But that's a requirement, and of course, it is variable across the system. So there are some options to reach out to one place or another, is there some availability? And would that person be willing to engage with them?

MS. ELIZABETH A. PATTULLO: You know what, I'm actually asking the question more in terms of the front door, you know, kind of entering the system. Because just from the popular kind of newspaper accounts, it sounds as though that is still a big challenge.

MS. A. KATHRYN POWER: So you're talking about the determination of eligibility for VA services, right?

MS. ELIZABETH A. PATTULLO: Right.

DR. LAURENT S. LEHMANN: We've got a requirement of anyone presents themselves on an outpatient basis, the VA to assess it within 24 hours for risk of danger to self or others, medical necessity, of course, and just as you would for any other kind of clinical condition. Crushing substernal chest pain, you know, what's cooking? Can you find out if it's cardiac or just GI distress?

So we really have that policy. And then to have a more complete evaluation. If they are urgent, emergent, they have to be seen then. Or if not, have follow-up within about 24, 48 hours. So you get some assessment of what people's needs are there.

The eligibility for care thing, of course, if someone presents urgently, you see what they've got first because that's just good clinical medicine. But there are pretty quick ways of checking if an individual is eligible for services. And the only people who aren't just automatically eligible for services are individuals who have what's called an other than honorable discharge, and that's an increasingly diminishing number of folks, and even in for mental health in terms of vet centers, there is some flexibility in some of those cases.

Well, you can hook up people who, for example, have bad paper at dishonorable discharge to work with prep service officer to determine exactly what was that, to what extent might those behaviors that led to the dishonorable discharge perhaps have been related to some psychological distress or problems or things like that. So there are ways of working with that. That is a bit of a longer-term

thing, but we really make every effort to -- assume someone comes in, to assess what they've got and treat them as quickly as possible.

And frankly, if they look like they've got a problem, but they're not eligible for care, to refer them to somebody in your community who can actually work with them.

MS. A. KATHRYN POWER: I've often found that many times, it just depends upon the State or it depends on the VISNs is that I will direct people to the State Departments of Veterans Affairs to get the information correctly about the best way to go about looking for the eligibility route for determination with the VA. Rather than trying to come in the VA side, come up through the Department of Veterans Affairs at the State level, who will generally have a pretty clear pathway to make that eligibility determination with the VA.

MS. ELIZABETH A. PATTULLO: Yeah, that's helpful. And really, my question comes from, you know, hearing this week that there was a backlog of 650,000 and a year and a half, and now we're down to 350,000 and that again anecdotally 7-month waits for determination.

DR. LAURENT S. LEHMANN: Pardon me, but that's not for clinical care. That has to do with determination of veterans benefits of service connection for particular problems, which is actually a separate thing from the clinical services, which is what I was talking about. That's a tremendous effort on the part of the veterans benefits folks and Secretary Shinseki's drive to diminish those numbers because those are complex cases.

DR. MARLEEN WONG: I just want to make a comment that might not be very well received, but I just want to say in relation to this last shooting that occurred, that if any -- that children who were born -- people who were born after 1985 grew up with a changed education culture, and that is they grew up with the knowledge that a school shooting was entirely possible.

And that when -- after Columbine in particular -- studies were done in schools, high schools in which they asked students, "Do you think this could happen in your school?" And as you might imagine, over 50 percent of the students said yes. And 35 percent of the students said, "And I'll tell you which guy I'm afraid of, that I'm terrified of."

I am not saying that military folks are more inclined to engage in this. I'm concerned about it, though, because there's a template for behavior, and most of these people are really suicidal.

I mean, they -- if you look at what the Secret Service and the FBI say it's that suicide and homicides are two sides of the same coin and that it's a process of fluidity that they are deeply troubled and are in deep trouble. So that the course,

the factors that either facilitate violence or decelerate violence are all -- are fluid.

But there's a template for this. You know, you get to the end, and you either kill yourself or you take out people with you. And so, these large-scale massacres, everybody keeps saying why is it happening? I don't know. I think, of course, 99.9 percent of the people find a way to cope with it and make their way through.

But I think that especially as these young men and women come home, we have to be concerned about it, just as we are concerned about it in the society as a whole.

So there are factors that are not specific to the military. There are factors that are specific to our culture and to our society, and I'm just -- you know, something happened. I'm sure we'll find out more about this young man. Maybe he was terribly depressed. But there are not actions that are strictly related to homicide. There are also other factors that are related to deep despair.

DR. LAURENT S. LEHMANN: Every coin has two sides. Military folks, by and large, people who go into the military, stay in the military, like the military, they like structure. They like order. We have a new series of videos on military culture that's coming out from our part of the VA/DoD mental health strategic initiative.

And this is one of the things they talk about. It's a very structured, organized society of people. The people who stay in that society like that, and so they're much more controlled and, therefore, somewhat less likely to act out impulsively like this. What's the flip side?

Increasingly, women in -- are joining the military and are having training in the use of weapons, and so what we see is that there are more women who are more familiar with firearms. And the risk of death by suicide -- I'm talking just about the suicide here, not violence. But the risk of suicide is always increased when a person uses a firearm. And so, now we have this subset of women who are more familiar with firearms and, therefore, are more at risk for a lethal suicide attempt outcome, and it's one of the things that we've got to think about.

So, by and large, the military culture is really good for helping people have structure and sort of almost selects for that, but there are other things about military life and what you learn in the military, such as familiarity with firearms, that has some risk issues to it.

MR. CHARLES OLSON: Regarding the Fort Hood incident, is SAMHSA available to do anything? Are they doing anything? I don't really know if that fits under any of the possibilities.

I know that SAMHSA does have some kind of emergency response, but I don't know, you know, more for -- is that larger-scale things? But I would love to see

for SAMHSA to make some kind of a either publicity or some kind of trauma, if they haven't already.

And the other thing that I just kind of wanted to comment on is that one thing that I learned when you're relating to people is you have to do something called matching emotions, and these soldiers are very used to urgent situations. You know, they spend their time over there worrying about life and death things.

And so, when they come back, they're very much in that same mode of thinking, as you know. And so, when they come to whatever service they're looking for, and they're like, "I need help, and I need it right now." And they get told, you know, shuffle some papers, and you're like, "Well, we'll see what we can do." That's not matching emotions. That's they're going to feel very unlistened to.

And I understand that that's a policy, and there is a lot of paperwork and a lot of procedure, but I know that my friends, they didn't get involved in the VA until it was a necessity. They were eligible for benefits. They could have gone at any time. They didn't want to go through it.

I mean, mowing the lawn, it's such a miniscule thing that's going on in their mind. They're worried about their life and death still. And so, to go into a service and be worrying about paperwork, they don't want to put up with that.

And so, I don't know if there's any way to make that more streamlined. I imagine that you guys have spent a lot of time thinking about that. But that's part of where the 40 percent is coming from. So these people don't have time. They don't have the desire to deal with that kind of paperwork and that kind of pushoff.

And I know that Minnesota just came under fire for one of the VAs destroying paperwork, and they're just missing this. These people that have medical requests out, that paperwork is missing, and the VA doesn't even know who these people are anymore. So --

MS. A. KATHRYN POWER: I'll start with a comment that I think that we need more people to step up and say what the issues are and how people are not being responsive because these are large institutions, and we need to have people speak about it. So we need to make sure that people who are in need of care have an advocate and have a family member or have friends like you who are going to speak out about it and challenge, frankly, the institutions and the bureaucracies. I think that's usually important.

I think there's much more of the technology and app approach that folks are taking in terms of some of the paperwork requirements so that they're trying to, I think, reflect more technological processing. I think this larger issue about your question about response is that SAMHSA does have, no matter what the disaster is -- and both manmade disasters and natural disasters or a person-

made disasters -- we respond immediately to not only the local authorities as appropriate, but to the State disaster response authorities.

And we have very quickly moved in with the disaster technical assistance center materials. We modify those materials depending upon what the event is, and we clearly see that whether these occur in the hands of an individual who's a civilian, like some of our school shootings, or in the hands of a military or former military person, the disaster response has to be quite the same in terms of supporting the community.

Sergeant Weaver just told me that we're having conversations with the U.S. Army about making sure that our disaster distress helpline is available to the U.S. Army contingent relative to what's happening at Fort Hood. So that's another asset, another resource that people can get immediately attached to.

So I think that the notion about -- about responsiveness and SAMHSA's looking at, first of all, the needs of the population, the way the population is changing, the way in which individuals coming into the military, oh, by the way, seemed to have maybe perhaps underlying behavioral health issues that should have been addressed prior to them joining the military, or the military should have done something about addressing them during their time on active duty, all of those things are what the VA and DoD are really looking at. They have to change, and they know they have to change.

And what is the military going to look like in the future with these kinds of demographic changes? How are we going to prepare for that? How are we going to be thinking about screening, assessment, et cetera? We just got asked the other day to sit on a I think there's a piece of legislation to look at a working group for prescreening people to go in the military. Should SAMHSA be doing that? I'm not sure.

What does the military want in terms of the kind of person that's going to be prosecuting wars in the future? Those are all profound, profound questions. But I think SAMHSA has an obligation to respond no matter what, and we have been. And I think we will continue to be flexible about making sure that the community's emotional health, that the immediate crisis and response are in play, that we help people recover over time. But that doesn't ease the burden of these very difficult crises.

I'm sorry, Kana, I have to go catch a plane. I apologize.

DR. LAURENT S. LEHMANN: There are some things like the --

MS. A. KATHRYN POWER: I'm sorry, Larry. Thank you all very much.

MS. KANA ENOMOTO: Yes. And thank you. Thank you, Kathryn, and Larry for

this very rich conversation. I appreciate it, and I think it's a good segue. The question around how do we communicate when an incident like Fort Hood occurs is a good segue to our next session about communication.

So we have -- I don't know if, Paolo, if you had anything else you wanted to add about our response?

MR. PAOLO DEL VECCHIO: No. That's fine.

MS. KANA ENOMOTO: Okay, great. Thank you.

All right. So thank you very much.

You've given us a lot to think about in this space around military families, and we will continue to be vigilant.

[Pause.]

Agenda Item: SAMHSA's Communication Strategy

MS. MARLA HENDRIKSSON: All right. So I should say good afternoon now since it is after noon. And I'm really thrilled to be here today to speak with you. I have spoken with other parts of the NAC over the last few days. So it's nice to also meet with you guys here.

I am Marla Hendriksson, the Director of Communications for SAMHSA. I've been at SAMHSA for a little over a year now. And I'm also learning so much more about SAMHSA and about the work that we do here. Communications is a very key component to that, and so I actually provided another set of PowerPoint slides to you rather than what was in the book earlier just so that we can have a more tailored discussion.

While I was attending the NAC the last few days, one of the things that I think you will agree resonated the most was the need for messaging. Messaging on all levels. It's important on so many levels in what we do not just for the general public, but for the workforce, for the influencers and other folks that we need to be reaching. And so, I'd like to take you through first an overview of OC, the Office of Communications, what we're doing with our strategic plan, what we've found in our research, and then, hopefully, we can engage in a discussion about how to actually develop those right messages for folks to understand and take action on behavioral health.

There we go. All right. So I don't have to turn my head.

All right. So the Office of Communications is an office that is with right underneath the immediate Office of the Administrator, and we are the most -- we are sort of the first line of defense, as some people would say, but we're also the mouthpiece. We are the folks that also handle the Web, which is 24/7. We are the ones who clear publications.

And so, it's important that the Office of Communications is a real key partner and collaborator to the rest of the centers when our products, for example, are created, when we have news and information that go out, and we help the rest of the agency crystallize our messages and other communications to make sure that folks on the outside have a greater understanding and recognition of SAMHSA and also of behavioral health. It's an ongoing task for us, and we are - - we do this by providing services and tools for the public, one of which is the Web, as I mentioned.

We hope that all the things we do make OC a one-stop shop for the resources and a way to also be the clearinghouse for things that go out . The Office of Communications has four major functions, as you see here. There is the way I would describe it to the outside would be we have our products. We have our public affairs. We have our Web and social media.

I understand that there was a very good session yesterday, in fact, on social media, especially with the youth and young adults. And I heard a few comments and praise, in fact, for our site as well as for our work along the lines of social media already. It's an ongoing and continuous improvement that we're trying to do, but I think we're getting there.

There are six actually main functions that the OC itself is doing right now. We're focusing on no doubt we have our press and our media. We have our digital communications, which is our Web. We are branching into more and more social media, which has expanded greatly just in this past year.

For example, with Twitter, when I came, there was only about 7,000 followers, and now there's over 40,000 just in the past year. So, you know, it definitely skyrocketed, and we are continuously looking for opportunities not just to use our campaigns and our -- and partnering with others to cross-promote things, but also to look at other social media channels without spreading ourselves too thin. There is a strategic approach for that.

Likewise, we have publications. We have a lot of publications in our store, and they've become more than just a print, moving on to digital. We have a lot of ePubs. It's become much more multimedia. Along those same lines, we have a lot of work on campaigns. I'm sure you've heard several of them already, like the Children's Mental Health Awareness Day that is coming up.

And two other areas that I want to branch out more on because it's so important

is the internal collaborations and liaison work that we need to do more of in OC not only to be more collaborative with the centers in things like a release from SAMHSA, but also so that we make sure that we have one voice.

The other area is doing much more market research. It's one thing to keep producing tools and publications and services. It's another thing to actually ping the outside to find out what they need. A lot of it is also demand driven. If we -- if we have a better understanding of what people need and what their concerns are, more likely we'll be able to not only tailor our message better to be better received, but also make sure that we have the products and the tools that people can make better use of. And I'll talk a little bit more about that later.

I also wanted to say that over the last few days, there has been a lot of talk about the theory of change, and there's no question that communications supports that. And in fact, it's embedded in each of the stages or the components of the "swoosh" or whatever you call it. But you know, I mean, communications will take different forms in each level.

I wouldn't really call it a stage because in some cases, some of the work is concurrent. So just suffice it to say that for each of these areas, there are communications that we are consciously looking at doing from the nascent innovation stage all the way to, obviously, the broad-scale adoption.

So I wanted to take you through a little bit about our communications plan. About almost a year ago when we started this process of creating a comprehensive plan for SAMHSA, one of the first things we did was we looked to the outside to find out how they perceive SAMHSA, what are their activities with SAMHSA, how others are using behavioral health. We looked at four different quadrants of key informants, and we spoke to over 50 CEOs in these organizations.

And the four quadrants that we chose were service providers, Government and policymakers, the public and influencers, and the business and insurers and payers. So didn't want to just reach into audiences that we already knew of, but we also wanted to stretch ourselves because, for example, we knew that there wasn't much of an audience with businesses and payers. So -- and insurance. So, definitely, we wanted to get their opinions as well.

The focus of our communication plan was to develop better messaging, to improve our areas of dissemination, to build greater public awareness, and leveraging the partners that we already had. And by doing that, we wanted to emphasize more collaboration across the board because it's more effective when others pick up your message and take it forward.

In fact, one of the things we found from this, this analysis that we did -- by the way, we did not -- we did reach out to key informants for real interviews with

them, but we also did environmental, traditional, online, and social media scans. So it's quite comprehensive in our approach.

We found that there were common areas of interest, and two sides of the same coin, the other side was some of these common areas of interest were also issues. So, for example, ACA. Last -- when we canvassed the outside, it was the first 6 months of 2013, and ACA was on everybody's minds, as it is now. Surprisingly, even before parity hit the streets late last year, it was already on people's minds, the need for and the interest in mental health parity.

Access to care was another area that we found from those key informants. Workforce development was another, and I know that we've had discussions here at NAC in the last few days on that. And lastly, we found that the integration of behavioral health with physical health also came up. So, again, those were the five key common areas or interests that we found out.

We conducted a SWOT analysis, and I wanted to go over with you some of the things we found from there, starting with what does SAMHSA do well? We found that the content, from what we've been told, the content was well presented. It's easy to read. The guidelines on clinicals have really greatly improved.

We have a lot of formats that people are starting to recognize that we produce and communicate in multiple channels. In fact, in the study, we found that the Federal Government has about an average of 26 key communication channels, and SAMHSA already uses 24 of them.

Do we want to use all 24, or do we want to condense it and then be much more efficient at using fewer channels? You know, this is one of our key concerns internally.

Another feedback point was that the information that's going out as far as our alerts is actually much more timely now. There was feedback on specifically on Native Aspirations, which is a tribal program, and there is greater collaboration with partners for our policy academies.

Where can we improve on? This segment was particularly important to me because when I came in, one of the areas that I was saying that we needed more improvement on was to make our publications, our products much more consumable. And not surprisingly, when the feedback came back independently, that was a validation. They said that, well, you know, you have a lot of great material, but it's not consumer centric.

You have these large reports, but not everybody can read all those and digest that. So you need to create formats and make the information more digestible for people because you have multiple audiences and multiple levels of

understanding.

Another area was a clinical and medical voice is needed. And so happy that our chief medical officer is here because she's helping really steer our efforts, our communication efforts moving forward.

Another area of improvement they said was, you know, your Web site really needs some improvement. And I heard yesterday that, yes, we have made some improvements. That was a comment noted, and I was glad to hear that because we are continuously trying to improve on it. It's a very big effort called Project Evolve. And hopefully, by the end of this year, we would have launched a new site that, again, has a better front face especially for our home page and make it into a more topic-driven approach.

Another area that is particularly something that I'm mindful of is how fast can we produce these publications and these products? We want to make sure that they are very timely and that, you know, they're not sitting on a shelf. So we're very conscious of that.

And then another suggestion was, you know, we have a very visual audience. So they -- there is a potential there to make our products a lot more visual, more graphic intensive, more infographic, and to give more "eye candy" is what they say. So opportunities, there are a lot of opportunities that we found, one of which was you really need to build the credibility of SAMHSA through the -- through benefits and impacts of our programs, both at the national level, but also at the local level.

One of the areas that we are very mindful of in the strategic communication plan, in fact, is to do that and to be recognized is to be a thought leader. If you can be a thought leader in the behavioral health field, you also increase your credibility, and the recognition of that defines your positioning, allows you to reach key audiences, and get to the influences and such.

We also have an opportunity to establish a more robust partnership with and expand our influence in new areas, and we are doing that already. For example, we are more mindful of working with primary care. And in fact, one of the components that I'm working on right now is working with WebMD and Medscape to reach new audiences in the clinical field.

And to do that, we are embarking on developing curricula through WebMD, which you can reach about 2 million practitioners out there, and the -- so we are going to be reaching them on both the clinical level and also the public side. Through WebMD through a curriculum, you can reach about 2 million practitioners, and on the public side, we are going to be reaching about 100 million to 200 million people who use WebMD through their apps, through their Web site, through the magazines.

WebMD is in about 90 percent of doctors' offices. So even if you have an ad that has messaging that is germane to SAMHSA, you get greater exposure out there.

Another area that we are looking to expand more on, and I'm glad we had discussions yesterday on it, is to really awaken the consciousness of youth and young adults. They are living in -- they're going to be experiencing a different world, and I know Pam has said that several times. And to have them understand that behavioral health is part of whole health from the get-go, so they don't even know a world different from that, is truly amazing.

Another area that we want to focus on is rapid response when we have incidents like yesterday's with Fort Hood and/or disasters, we want to be able to be in the moment when we put out our messaging, to be most relevant, to be timely, to be in the conversation. I think that is really key.

And what would SWOT be without threats, right? So the T in SWOT is something that we want to be mindful as well. Our work is still -- is also subject to how much money we have. So one of the areas that the informants said was a threat was, of course, budget cuts. Another is any kind of restriction that may limit SAMHSA's ability is another -- is another for that.

We also have a threat in terms of how would people react to SAMHSA going forward to say that it is leading the behavioral health of the Nation? And another perceived threat -- again, this is just feedback from the outside -- is the recognition as -- SAMHSA's recognition as a first line of choice in the behavioral health field.

So one -- the other thing that I wanted to touch on before we go into a discussion is so, given these considerations, what type of messaging should we have that would resonate better with our key audiences? I wanted to give an example of something we used last year for the launch of our mentalhealth.gov Web site. This message development centered around four key messages, and again, this is very simple and broad because we wanted to focus our example on -- mentalhealth.gov is a very basic Web site to just raise the public awareness of mental health issues.

So, again, it's a very public-driven messaging, and it's very simple. There's four key messages. One is that it's okay to talk about mental health. Help is available and effective. Get help if you need it. And if you know someone in need, help them get help. And this is where we move people to help-seeking behavior and focusing on treatment and all that.

The messaging was also found to be so resonant that the National Association of Broadcasters also took this messaging for their campaign last year called

OK2Talk. National Association of Broadcasters is a very strong partner and stakeholder in many of the things we're doing from a media education side, and we are really hoping to improve or increase our partnership with them.

But, so you see here, I mean, even for the mentalhealth.gov, there is key messaging that was developed. I imagine that when we look at other messaging that has to -- that we have to focus on, it would have to be tailored to the different audiences, especially since some of them are more clinical. Some of them are much more sophisticated. We can develop messaging for military and veteran issues and trauma issues and such.

But there has to be an overarching message, and hopefully, that the whole point of that is to increase the engagement not only of the people in our workforce that we need to reach, but also the general public.

So I wanted to shift gears and actually use the rest of the time to chat. I think in your binders, they provided a set of discussion points, and if you don't see it readily, I can certainly pass around these sheets. Tab 4? Okay. All right.

So seeing as messaging has really resonated with the discussions that have happened in the NAC the last few days, we wanted to use this last segment of the NAC to really -- to start that discussion. I imagine it won't end here, but certainly more food for thought. So we were hoping to ask some questions and start to think about the types of messaging that we need to be more focused on developing and putting out there.

Question number 1 has to do with the nexus of behavioral health and physical health. I think this is something that we can't take for granted because this is one of the key things that people need to understand. So where does behavioral health and physical health intersect, and how does one impact the other?

DR. ERIC B. BRODERICK: They intersect in every human being. I mean, it's us. It's in all of us. So, I mean, that's where -- that's the connection because we seek care or not from providers all across the spectrum of health and behavioral health and everything else, go to Walmart, all that. So that's the common denominator. I mean, it's pretty clear to me.

How do we communicate that intersection? You would think that people would understand that. How to talk about it, I guess, in a way that people find a teachable moment, if you will, to -- whether to create demand for a service or raise expectations about what they get, where they get it, and how they get it is a little bit more complicated, I guess. But I think you start at the person level.

MS. ELIZABETH A. PATTULLO: Somebody yesterday said mind, body, spirit, and that sort of hit it for me as a way of at least approaching it, and then from there I get a little lost.

DR. JUNIUS J. GONZALES: I'm not going to answer the first question. No, I'm a rebel, right, because there are sort of content issues, process issues, strategies about subsegmentation. I liked your long slide presentation -- I was trying to flip through it quickly -- in terms of all of the data gathering, the 49 slides.

So, so you can come and work for us because we're having the same issue even more -- with a more segmented population. But I guess I'm very curious about 7 sort of drives all of the content and process stuff. So I'm sure you all have had discussions about whether you should have almost directed portals once you hit the main page in terms who the person is and kind of what they're interested in and move them that way.

Because right now, like many Government Web sites, a lot of great information, but you're kind of overwhelmed by the first page. There's a lot of stuff. And so, I was curious about that if that's what you meant by consumer centric, or did you mean behavioral health consumer specifically, broader consumer?

MS. MARLA HENDRIKSSON: So to make our publications, our products more consumable simply meant that we can't expect the general public to pick up the NSDUH report and understand what it is, which is so many hundreds of pages. They barely know what SAMHSA is, for a large extent. So how do you -- how do you first expose them to SAMHSA and the work that we do? But also how do you get them to understand what behavioral health is, let alone to be more sophisticated in digging, you know, looking for a NSDUH?

Do we want to create -- I call it the "bite-snack-meal" approach. So the bite would, you know, if we had a big NSDUH that you're rolling out, we don't just put the report out there and say here it is. We would say, well, yes, we have a press release. We have a blog. We have social media activities. We have short reports. We have fact sheets. We have multiple ways to reach people on different levels. And again, making it more consumable, especially if you're trying to direct new audiences and get them exposed to the work.

As far as the Web site, as we retool SAMHSA.gov, we are shifting from a site -- the current sites are very program driven. We are turning that to be more consumer oriented, not mental health consumer, but public, and in doing so, we are changing it from a topic-based approach. Not so easy. But as we do that, we are also looking at the different audience segments.

So this type of discussion is really helping us sort them into the right buckets in terms of content, but then also saying, okay, for this type of content there might be multiple levels of engagement.

DR. JUNIUS J. GONZALES: Yeah. Now that's great to hear. It is very hard. I

mean, with the amount of material that you have because if someone, you look at the four, five groups and let's say someone is interested in depression and heart disease, I'll just make that up, because there was an example about 10 years ago of someone that I knew who was working on this. And so, there have been some successful sites. Again, albeit on much smaller topics.

But one at my previous institution where they developed a child welfare site with entries for parents, for service providers, for policymakers, et cetera, and I'm glad to hear that you're thinking about this. But it is very hard because you want to keep your message about depression and cardiac disease the same, but it's going to be presented very differently to the five groups. But that's exciting.

MS. MARLA HENDRIKSSON: Thank you.

The other thing I want to point out with that strategy is we are also trying to partner with other entities out there, like CDC, who are known for large campaigns like the Million Hearts that is getting a lot of broad-scale exposure. And you want to be able to get others to carry your message, and so in that case, we were successful, in fact, in putting our behavioral health messaging into Million Hearts. So that people have -- people who don't know about behavioral health but know that depression may have a physiological effect on you, then they start to sort of open up to that.

Another thing I wanted to point out is for that last bullet, it's a very broad bullet on other influencers, one of which is media and the entertainment industry. This is an area that we are carefully cultivating to make sure that they do understand the nuances of behavioral health and then more responsibly portray them in the stories they cover, in the -- removing their biases.

And also, for example, with the entertainment industry, it's the movies. It's the TV shows. It's the things that people are subliminally exposed to. And that create -- and those things create biases that they weren't even aware of. So we're trying to change all that, and we are very -- we are partnering with groups like the National Association of Broadcasters and the Entertainment Industries Council so that they can carry our message forward.

MS. KANA ENOMOTO: I think another complicating factor in this process of creating a dynamic Web environment is that we are consolidating from many, I think, close to 100 Web sites now down to 65 or so Web sites, and then down to 1 or a handful of Web sites, which each of which had its own look and feel, its own viewership, its own orientation and audience. And so, bringing all of that together is incredibly complex.

Behavioral health has a very broad spectrum of issues and topics. So, in addition to multiple audience, we're not just -- and I'm sure NIDDK, you know, has a huge -- just looking at diabetes and kidney disease, I'm sure they have a

lot of things. But we are looking at multiply that by many more aspects of people's lives from childhood to old age, from education and criminal justice, housing and the medication, the recovery support, the prevention. I mean, everything is in there, every aspect of -- behavioral health touches every aspect of people's lives.

And so, we have a Web site for pretty much every one of those, and bringing all that together with the different audiences is incredibly complex. But we're very lucky to have Marla. She's an extremely strategic thinker. She embraces data. She uses data to make decisions, to inform our priorities, and that's really a fresh -- a breath of fresh air for us in terms of how we're going to create a robust communication strategy.

I think it's much more analytic than we've been able to be in the past, which is great.

DR. MARLEEN WONG: I just want to share that I participated in one of those SAMHSA activities in Los Angeles, and 30 screenwriters, we met at CBS City, Television City. And they just asked questions. I think it was Dr. Felitti and me, and it was fascinating.

They were writing about people who were traumatized, had been exposed to certain kinds of experience, but didn't -- wanted to know how that might play out in people's lives with their families. I mean, they asked great questions.

So thank you for that.

MS. MARLA HENDRIKSSON: Absolutely. We are finding from these partnerships that there is a real conscious effort on their part, the ones who are already conscious or really much more exposed to these types of issues, that they have a responsibility to portray them in a more accurate light.

But there are -- while there are segments that do that, there is a lot, there is a whole slew of media that is not. You can pick up the paper every day. You can look at any blog out there. We track -- we have a media tracking system that not only tracks SAMHSA, SAMHSA coverage in the media, but it also tracks deeper tone coverage of certain terms and how they're used.

Last year, we had a study on social media alone using what terms are people talking about? What their conversation about? Nine hundred different terms came up that are related to our work.

It's still very fragmented. We're trying to understand those 900 things and what's driving them, and maybe we can distill them into more logical groupings, for one, but also how do you then create messages to be relevant to people on the outside? And how do you, once you are relevant, how do you engage in

conversations with people?

It's one thing for SAMHSA to just go and put a tweet out or put a Facebook out, but it's another thing to get in the conversations of others. And I think that was a discussion that happened that was raised yesterday. One person said I can get up in the morning, and I can look for a particular hashtag and then join a conversation.

I think that's a great strategy for any person because it personalizes it. But for an organization like SAMHSA where you have an agency voice or a Federal voice, it's a little different, and we have to be mindful of how we engage and at what point we do that so that it doesn't look like we are imposing on them. And they're more open to a conversation when they know it is a conversation. It's not just putting information out.

So there were a couple of other questions here that at the very least I'd like to tee up, and then we can certainly reach out to you offline for your feedback on it, if you feel like doing that.

I mentioned earlier about do we have an overarching message? Should there be an overarching message? And I think there should be, but what would that be when we are different things to different people? And my special assistant wrote this. He said if health integration was a movie poster, what tagline would you have? I thought that was quite interesting.

[Laughter.]

MS. CASSANDRA PRICE: I'm trying to envision that from a Hollywood perspective, and I think it's finding the intersection of calling it something besides health integration, first of all. And figuring out from an audience perspective how do you sell that as something that is a part of overall health and wellness. I kind of like the mind, body, and spirit, kind of all those things, the connection of your behavioral health to your physical health, and how do you make that in a way that I wouldn't say is sexy because that's not the right terminology. But it's still that same concept of that it grabs the attention of someone and in some way they buy into it.

So I think it's a challenge, but I think it's all about -- it's all about branding, and it's all about maybe getting some input from your target audiences and some young people and who have creativity and, as somebody mentioned, is working in a garage somewhere. Because I think it really is about not using the same old stuff and verbiage and things that we think of. So --

MS. MEGAN GREGORY: I serve on the Center for Native American Youth Board, as I mentioned earlier, and something that I like that they're doing is they're reaching out to young people across Indian Country to address some of

these issues that we're discussing here today. And not only highlighting the negative, but also sharing the positive that's happening.

And so, I think it would be interesting to figure out who your champions are and have them share your message and how they can get this information across to younger people. So, for instance, Charlie and myself, I think it would be great if you'd reach out to us more and let us know what we can do to help, and then also look at the national level.

I know there's a campaign for -- yeah, a campaign for a presidential youth council. I'd like to see what's happening with that group. I haven't heard much lately. I also work with the National Council of Young Leaders through Youth Build USA.

So I think reaching out to those councils at the national level and working, whether it's with one or two members, but sharing your message with them so that they can share it with a younger group of people because I think that peers will be more inclined to listen to people their age, and that's a good place to start.

MS. MARLA HENDRIKSSON: I'm glad you mentioned that because I had a very rich discussion with the TTAC the other day. The chairman raised his cell phone and said, well, I know that for most of the youth, they have smartphones, and they do keep in touch with each other this way. Why don't we make it more useful to reach them because they also have a way of reaching the elders.

So, and the way to do that would be through social media. While we have our regular channels for social media, it's hard to distill a message in so many characters. So we're looking at other types of social media, for example, like Storify or Tumblr or Instagram or others and using also more visuals for our data so that people can easily pick it up and say, oh, yeah, this is more interesting. I want to learn more about that.

As far as reaching Native populations, for example, I mean, we had a great discussion of the use of stories, in fact, and that's why I mentioned Storify. Because as people share their stories and they feel like it's a safe environment to do that and it's among their peers, it's more likely that they will not only use the platform to share messages, to share their experiences, but to take our message forward and, hopefully, put their spin to it.

But again, the more people are more conscious of that and can take it -- can speak to it with their personal experience and in a way that, for example, the youth can move it amongst themselves, it gets a life of its own.

MR. CHARLES OLSON: I'd like to just kind of second that. And then you were mentioning that there was a lot of different Web sites for a lot of different populations. I was curious if there was ever either a separate Web site or kind of

a category in a Web site that was more focused on youth and young adults? And I know that you're in the process of kind of combining a lot of these together. So I was curious if that was going to stay or if the new Web site has a location that would be more friendly to youth?

I don't know what the viewing would look like because I have to admit that I'm probably the only youth that I know that would ever go to SAMHSA.gov. But --

[Laughter.]

MR. CHARLES OLSON: -- there is ways that you could make it a lot more -- and that's not being critical. I just -- there's nothing wrong with your site, but I think there's ways to make it more friendly.

And then the other thing I'd like to mention, you know, reaching out to us a lot more. We have a lot of valuable insight into youth, and additionally, we're really good at technology. So --

MS. MARLA HENDRIKSSON: Just, so answering your question about the sites that have a youth/young adult component. From what I've seen, there are -- some of it is more topic driven, like if the topic is on child trauma or so but we are trying to find ways to be able -- for the visitors of the site to be able to segment the material so that there is a ready audience for youth and young adults. There are many parts of our site that have components that serve youth. But it's not like there is a page on youth.

DR. MARLEEN WONG: Well, I'm learning from my own university, the program that we have. I went on weather.com and up came a USC School of Social Work ad that was total shock.

So, I mean, are there other Web -- I don't know how much of a marketing budget you have, but sometimes it's not just the Web site, but it comes up, it pops up a question like, you know, do you know someone in trouble? Do you know somebody who you're worried about or whatever. And it comes up on another Web site, but it's a Web link to you, SAMHSA.

MS. MARLA HENDRIKSSON: Yes, in fact, while we can't do that from our site, we are using Google, like Google ads and Facebook ads, which are targeted depending on the user. If the user signs in as themselves and they're -- in their profile, they have certain things like, oh, they're a psychiatrist or they're at a university, those markers on your profile actually predetermine or populate the ads on the right, just like if you go into Candy Crush or some kind of game or app, and you get these ads.

It's like what am I -- how do they know that I like Hello Kitty or something? Because it's something in your profile will tell them that, and it's quite a bit of

marketing underneath, but yes, we are conscious of using Google ads and Facebook ads and others to begin to do that.

Last year, when we were doing the big promo on mentalhealth.gov and we did a big push on Twitter, we were number two on Twitter for that topic. Number one was McDonald's only because McDonald's paid for it. So they paid so much money to be able to push out something on Twitter, no matter what the topic was. But if you cancel out that more paid subscription type of thing, we were the number one for that day when we posted.

Another would be using -- and our campaigns are very good at this, when they use spokespersons that resonate with the youth. Last year for Children's Mental Health Awareness Day, we chose Demi Lovato, and she was very effective at reaching new audiences because she's very conscious about these issues. And in the prelaunch of the campaign, she did -- she did one tweet, and her one tweet alone reached 20 million people in 12 hours.

So we didn't quite crash Twitter, but we set a record for HHS. So there are ways to do that, and kudos to CMHS for very creative strategies. So stay tuned to see this year's spokesperson.

MS. KANA ENOMOTO: Thank you, Marla.

Are there any other comments from council about this communications topic?

[No response.]

MS. KANA ENOMOTO: Okay. Well, thank you very much for that. That was really helpful and I think gives council a sense of where we're going. And you've given us a sense of what opportunities we might leverage better or more to advance our causes.

I would like to take a little bit of time. I think we'll adjourn early. Are we allowed to adjourn early? Yes. But I would like to take a little bit of time to reflect with you all about where you would like the next meeting to go in terms of topics and/or if you feel like we would benefit from another Joint National Advisory Council meeting in August, which will be virtual.

So we're doing a virtual NAC meeting, and the question is whether you think we should convene the collective of all the committees virtually as well. So any thoughts on that, as well as thoughts for priority topics for discussion next time?

DR. MARLEEN WONG: Well, I think how is ACA progressing and how is the integration and how is it being defined? What part of it is being sort of addressed as we go along because it's fast moving, the fact that all of a sudden over 7 million people when there was such doubt about it at the beginning, it's

obviously quite successful. So what's the next iteration?

MS. DEE DAVIS ROTH: It seems like the two meetings tend to focus differently. In other words, the joint meeting tends to be a lot of reporting out and what's happening. And I think that's really valuable, whereas this tends to be more conversational, gnawing on things, and less just give us all the information about what's happening in the hot topics. So I think both of those are useful.

MS. KANA ENOMOTO: So that's a vote for a Joint NAC and a NAC virtually in August.

Ric?

DR. ERIC B. BRODERICK: Sorry, Charles. But tell me what a virtual meeting looks like. I'm having trouble picturing how this is going to be. Okay. Thanks. Charles and I are wondering what a virtual meeting looks like. Tell me I'm not going to have a phone to my ear for 8 hours. Just please, Kana, tell me that.

MS. GERETTA WOOD: It would be a teleconference with a Web conference attached, and so you can view the slides and that sort of thing on the Web on your computer while you're listening on the telephone.

MR. CHARLES OLSON: Have we -- have you guys done this before? Has it been successful? I mean, I know what it looks like and how the process works. I'm trying to imagine it with a large number of people, and I'm getting the shivers.

MS. KANA ENOMOTO: We have done it before to some degree of success. We just had in March a call on the SI paper, and that was just as a preview to folks, and about half of the council members logged into that, right?

But that was shorter. I mean, even that was 2 hours, but that was not 8 hours of online conversation. When we have done the Joint NAC virtually, I don't know that we got a lot of conversation stimulated. I'm sure we had some fine presentations, but it was harder for people when there's 70 people on the line, I think it's harder to jump in.

And you can't see the body language. I can't see someone jotting down their notes and preparing to say something. So it's a little bit more challenging.

However, between now and August, and actually in the last year we've been trying to do more thinking about how do you -- you can't do a meeting the same way that you do it in person when you move it to an online way, and so I think we can also be a little bit more creative in how we implement.

Ric, then Larry, then Marleen.

DR. ERIC B. BRODERICK: Why? So why did you choose a virtual format? I mean, I can think of a number of reasons. I'm just wondering what your reasons were.

MS. KANA ENOMOTO: Resources. You know, some of it is the cost of the convening and the travel. Some of it is at one point when we were doing our conference clearance forms for the department with the activity that we had there, that NACs were not exempt. For a while they were exempt. Then they weren't exempt. And now they're exempt again.

So when we made the decision, they were not exempt. And so, we were having to do massive clearance forms for them. So it seemed smart to do half as many, but that was -- those were some of the considerations.

But anyway, so it's complicated. I think the other thing was that some people had asked for it. Some members had said do I really need to travel to D.C., or is there some information you can share with me where I am? And I'm more likely to participate if I don't have to make the 2-day trek from Anchorage for a 1-day meeting. So it was kind of a balance of accommodation.

So Larry, then Marleen, then Charles again.

DR. LAURENT S. LEHMANN: Well, just one suggestion. Yesterday, I dialed in to the call, and the audio was very, very good. One of the things I might suggest, because we've done a number of webinars for exactly the same reason that you all did, these strictures against spending for travel, is that if you might make the slides available perhaps on a password-protected Web site where the folks who need to access it, can access it and either download the slides or click into the slides or something like that.

Sometimes there are things like Adobe Connect or Live Meeting where everyone who can dial into the system sees the slides as you're going. You can ask questions electronically. So I don't know if you all have that system or not. That tends to work well.

But if not that, just the possibility of doing it because if you can -- sometimes you can dial in audio, but you can't see the slides. So to have some opportunities for the council members to see that, it's a lot easier to get an almost live experience and get as much out of it so we can interact more and know what's happening.

DR. MARLEEN WONG: To the extent that there's ability also to just type in questions that you could moderate later, that would be very helpful so that we have to save it all for the end. I just don't see how we could do it for 8 hours. I speak for myself. I don't know how I could do it for 8 hours.

I mean, I'd either have my head down, or I would lie down on the ground, or I

mean, something would have to happen for me to be able to hang on for 8 hours.

[Laughter.]

MS. KANA ENOMOTO: Yeah, again, I think this is a growth area for us, a learning area. And so, the first thing we did when we moved our meetings to virtual was we did -- we planned for a regular meeting, and then we did it by phone, and I think 8 hours. Even this 4 hours is, I think, dragging on people who were here for 8 hours yesterday. So I think we need to go the bite-snack-meal approach maybe for some of this.

Charles?

MR. CHARLES OLSON: I guess I just want to officially say that I do have some concerns and reservations, but I am -- I'm curious to see how it goes. I think, as far as you mentioned, there are members that have come to you and said that we'd like to have information given to us locally. I think there is a way for that.

Let's say that in the future you keep these physical meetings. I don't see why there wouldn't be a reason to have smaller groups of people to meet virtually over specific topics. I think that there could be increased communication with members either individually or on small topics.

And I know that you guys are stretched in resources, and you don't want to have many conferences throughout the year. But I think that you might find that your advisers do want to have that contact with you. We do appreciate it when you reach out for our advice, and it might save you time in the long run.

MS. KANA ENOMOTO: So every time we bring together more than one council member, it's a FACAs, right? So we have to do a Federal Register Notice. So there are -- I mean, there aren't sort of technical, like technology reasons why we couldn't. But there are some administrative reasons why it's a little bit daunting every time we pull people together.

So doing it four times isn't super appealing, although, you know -- but right. But I think something in between is certainly possible or doing a couple of topic-based Joint NAC calls where people who are interested in that particular session could dial in and something like that. So, I mean, I think you're giving us good food for thought.

Marleen?

DR. MARLEEN WONG: Yeah. This is probably just as much trouble, but it would be interesting, for instance, to have us go to perhaps the regional offices of SAMHSA so that we could sit together with people. Alaska's probably goes to

San Francisco, I don't know. But have clusters of us regionally in which there is sort of a presentation, and then we do some work with a smaller group. But we also have an opportunity then to get to know who our regional person is and what they're doing and how it relates specifically to our areas.

MS. GERETTA WOOD: I know. That does sound wonderful, but if we called it an advisory council meeting, it does fall under the rules of FACA, and we're bound to the Government and the Sunshine Act and we have to announce it to the public and allow the public to participate. And that is triggered if you have two or more members in the room.

MS. KANA ENOMOTO: But it is -- but I think that as an idea, as an alternative to one of our in-person meetings, that's a possibility. It wouldn't -- the other thing about the conference is anytime we travel somebody, then it's a conference. So assuming that not everybody lives in San Francisco or Atlanta or Philadelphia, it would mean that would still be a conference, as we're defining them, and so we would have to do probably either 1 or 10 conference forms and Federal Register Notices and things like that.

But that being said, it's, I think, a very innovative thought, and certainly it's something that we should think about, how do we -- because I think the council members would enjoy getting to know our regional administrators and understanding what kind of impact they have and how they can help amplify the role of the RAs sort of where you are.

Charles, then Ric.

MR. CHARLES OLSON: I wanted to clarify. So the virtual meetings are not subject to the Sunshine?

MS. GERETTA WOOD: No, they are.

MR. CHARLES OLSON: Okay.

MS. KANA ENOMOTO: They are Federal Advisory Committee meetings, but they don't fall under the conference policy clearances because they don't involve travel.

DR. ERIC B. BRODERICK: I'm off of the virtual meeting now. I'm back to the other question about topics. The one you just mentioned I think would be pretty interesting. I think those folks have been out there in the regions now for a couple of years, and sort of getting a sense of what they're up to and how they're doing it and the impact they're having on the agency, that would be interesting to me.

MS. KANA ENOMOTO: And are going gangbusters. They're going

gangbusters.

Other topics?

MR. CHARLES OLSON: I actually was going to mention that when Kathryn was still here. I would love to see more or hear more from the regional administrators. It was actually Dr. Jeffrey Coady from Region 5, I believe, that nominated me. So I'd really love to hear from him.

MS. KANA ENOMOTO: Others who have other topics that would be important to you or that you would want other updates on? So I have ACA implementation update, which I'm not sure by August we'll have gotten too far, but -- and then the RAs, which actually if we're having a virtual meeting, that's pretty easy to do. Yes?

DR. MARLEEN WONG: I think people coming home from war. I would love to hear progress on what's happening on the military front.

MS. KANA ENOMOTO: Particularly around reentry issues, Marleen? Okay. Others?

MS. DEE DAVIS ROTH: Are you assuming that the integration topic is in and under the Affordable Care Act conversation? Because if isn't, it needs to be a topic, I think. We've talked about this so much, I think that a progress report, a here's the new developments kind of a session would be useful.

MS. KANA ENOMOTO: Okay. So a revisiting of integration, RA, an update from our regions, reentry for service members and veterans, ACA implementation.

Okay. And I just want to give a nod to some of the topics that were brought up earlier by Chris, Junius, and Henry. They talked about, and I don't know if any of you guys want to weigh in, as possible topics around micro-innovation, incubation, measuring health outcomes, and maybe that's an integration piece.

Telehealth, teleprevention even, and distance learning you guys have both brought up. We didn't have sort of an HIT conversation here today, but you both raised it.

Prescription drug abuse and gun violence, those were two other topics that were raised as issues.

DR. MARLEEN WONG: Also SAMHSA's role in Now is the Time. I mean, it will be closer to the budget being approved, I'm assuming. I would hope and all that, but that would be interesting to know.

MS. KANA ENOMOTO: It's a little raw at the moment. But, yes, I think that

would be -- by August, we'll be in great shape, yes. We're in the throes. We're in the throes of those conversations now in terms of getting those grants out the door, and we're really excited, and I think by August, we'll know sort of how many applications we've got in, what -- exactly how the programs are taking shape. So that's great advice.

We do think that the behavioral health professions workforce, they're called FOAs, from HRSA are going to be coming out today, today. So the 35 million for workforce development is coming out today. So be on the lookout for that, schools of social work.

Other topics? I think that's good. I mean, I think it's probably more than enough for one meeting. So we'll bring that back to the Administrator and see where she lands on that.

So thank you.

Agenda Item: Public Comment

Josh, do we have any public comment? Okay. All right. So do we have any public comment, Operator?

OPERATOR: No, we do not. But if you would like to ask a question, you can press *1. Again, if you would like to ask a question, you can press *1.

[No response.]

Agenda Item: Closing Remarks and Adjournment

MS. KANA ENOMOTO: Okay. Well, thank you very much. Thank you to our members.

We are adjourned.

OPERATOR: This now concludes today's conference. All lines may disconnect at this time.

[Whereupon, at 1:16 p.m., the meeting was adjourned.]