Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
National Advisory Council

MEETING MINUTES: AUGUST 17-19, 2005

August 17, 2005

Closed Session

The National Advisory Council of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) convened in closed session on August 17, 2005, at 9:00 a.m. at SAMHSA's headquarters in Rockville, Maryland, for a secondary review of grant applications. CMHS Director A. Kathryn Power, M.Ed., presided. Council members present over the course of the three-day meeting included Cheryll Bowers-Stephens, M.D., M.B.A., Larry Fricks, Jeffrey Geller, M.D., D.J. Ida, Ph.D., Timothy A. Kelly, Ph.D., Judge Ginger Lerner-Wren, Carlette Randall, M.S.W., and Michael Vergare, M.D. Also present were ex officio member William Van Stone, M.D., CMHS Deputy Director Ted Searle, M.B.A., and Council Executive Secretary Dianne McSwain, M.S.W. The closed session adjourned at 3:00 p.m.

August 18, 2005

Open Session

WELCOME AND OPENING REMARKS

Ms. Power convened the open session of the CMHS National Advisory Council on August 18, 2005, at 8:45 a.m. and welcomed participants. Council members introduced themselves, and Ms. Power introduced Dianne McSwain, new Executive Secretary of the Council.

MINUTES

Members of the Council voted unanimously to accept the minutes of the February 2005 Council meeting as amended.

MENTAL HEALTH TRANSFORMATION: UPDATE

Ms. Power referred Council members to the printed Director's Report and presented an update of mental health transformation activities. In July 2005 CMHS presented its Federal Action Agenda to Congress and to a large group of constituents. With the addition of the Departments of Agriculture, Transportation, and Defense, CMHS's Federal Partners Workgroup for Mental Health Transformation now includes nine departments and the Social Security Administration; the Office of Personnel Management also has asked to join the group. The Action Agenda represents approval by the federal partners of 70 discrete action steps that can make a difference quickly. The principles of the Presidents New Freedom Commission (see box)—consumer/survivor opportunities in the community, models of comprehensive community-based

care, maximization of existing resources, use of research findings to influence service delivery, and promotion of innovation, flexibility, and accountability at all levels of government—guided compilation of the action steps. The Action Agenda is to serve as a living document for a multiyear effort across all levels of government. With the creation of the Federal Executive Steering Committee, for the first time a federal body of senior officials will guide transformation efforts across the departments and agencies they represent. Members will include, for example, the administrators of SAMHSA and the Centers for Medicare and Medicaid Services, and the director of the National Institute for Mental Health. In another significant event the Campaign for Mental Health Reform, a coalition of sixteen national mental health advocacy groups, issued its report on mental health reform. The report outlines 28 steps for Congress and Administration to consider. Members of Congress have called for prompt, decisive action.

Ms. Power highlighted the importance of collaboration across all levels of government and of learning from consumers and families. Although the federal government can provide resources and use its convening power, real opportunity exists in states to make a difference.

CMHS has incorporated National Outcome Measures (NOMs)—which focus on positive outcomes such as employment status, stability of the family, and living conditions—into state mental health block grant reporting requirements and plans to devise a method to build them into all CMHS discretionary grant programs. Ms. Power stated that NOMs will be a test bed for measuring what recovery means for consumers and for pinpointing where states most need to transform themselves to assure access to resources and supports. SAMHSA Administrator Charles Curie has pledged to Congress to implement NOMs across SAMHSA in 2007, which will enable Congress and consumers to judge programs' effectiveness.

State Incentive Grants for Mental Health Transformation (Mental Health SIG grants) provide seed money to help states build infrastructure to weave together mental health financing, planning, services, and evaluations, all conducted by multiple systems for both adults and children. Six or more grants totaling almost $19 million will be awarded in September 2005, and increased funding for a second round of grants is included in the President's FY2006 budget. Some states already have begun transformation efforts, and CMHS and the National Governors Association (NGA) are providing technical assistance, including helping teams of high-level state government officials to develop states' visions and consensus on priorities and strategies.

The Transformation Action Initiative (TAI), an effort to organize CMHS's transformation work, is considering using technical assistance brokers to tailor technical assistance plans in response to states' transformation priorities. CMHS spends more than $44 million annually on more than

Goals of the New Freedom Commission on Mental Health

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

fifty technical assistance efforts to improve services, make mental health services more trauma informed, develop alternatives to seclusion and restraint, and eliminate barriers to treatment. The TAI's goal is to identify ways for states and tribes to navigate among technical assistance efforts more easily by centralizing information and building better connections. CMHS will test some of TAI's principles and work with the first Mental Health SIG grantees.

All transformation efforts aim at creating a mental health system focused on consumer-driven recovery, but stigma and discrimination remain major barriers. CMHS's three-year National Anti-stigma Campaign, launched in October 2004, has completed the first round of research and outreach strategy, conducted an expert symposium, held an agency kickoff meeting, and convened a first meeting of a workgroup of private and public members to promote the national campaign. PSAs will be ready for media release before the end of 2005. SAMHSA hosted the first Voice Awards in Los Angeles in July 2005 to recognized film, TV, and radio writers and producers who have created positive, accurate, and dignified portrayals of persons with mental illnesses. The awards also recognized mental health advocates and persons whose activities promote mental health awareness.

Discussion. Dr. Ida commended CMHS's work across all levels of government and outside mental health. Ms. Power echoed the need to work with people outside the mental health system, where larger social change will emerge. She responded to Judge Lerner-Wren's inquiry about how the Action Agenda will reach states by stating that CMHS currently works with the NGA and Council of State Legislatures at the policy level on approaches to transformation, including a series of regional meetings for states. In addition, federal partners influence their state counterparts, for example, the Department of Labor engaging states' One-Stop Centers for Employment to achieve leverage. To Judge Lerner-Wren's question about how transformation relates to managed care reforms and Medicaid, Ms. Power responded that Mr. Curie has encouraged CMHS staff to brief CMS about understanding and aligning with transformation. Acknowledging that Medicaid is a state issue, she identified the need to make arguments for not abandoning Medicaid for persons with mental illnesses. The auditing process is a concern, and reforms are rumored to be planned to change eligibility definitions. Dr. Vergare expressed concern about Medicare and insurance because of barriers and discrimination related to co-payments. Ms. Power noted CMHS's small role in the issue, remarking that dual-eligibility payments are a concern.

SAMHSA ADMINISTRATOR'S REPORT

Charles G. Curie, M.A., A.C.S, described how his personal experience with a medical error resonated with his understanding of how persons with serious mental illnesses have been "treated" through time. He highlighted the importance of both the Federal Action Agenda and the federal partnership that developed it. Mr. Curie announced the departure of former SAMHSA Chief of Staff Gail Hutchings and noted that Secretary Mike Leavitt has issued a 500-day plan for the Department of Health and Human Services. He explained how selected SAMHSA's issues align with the core principles of the 500-day plan, which also aligns with the SAMHSA matrix. Mr. Curie noted that members of the SAMHSA National Advisory Council serve actively as ambassadors to bring SAMHSA's values to their communities.

Mr. Curie noted that President Kennedy signed the Community Mental Health Act in 1963 and that in 1979 President Carter's Mental Health Commission report described a community-based system in specific terms. The next major federal focus on the issue was the 1999 Surgeon General's Report on Mental Health, which outlined the science that underpinned its assertion that treatment works for mental illnesses. In 2002 President Bush announced creation of the New Freedom Commission on Mental Health to study and identify gaps in the nation's mental health system. The commission issued its report in 2003, and SAMHSA took steps to set an action agenda with a focus on consumer and family and the expectation of recovery.

Mr. Curie highlighted SAMHSA's Access to Recovery substance abuse program. The administration is addressing actively the issue of methamphetamine, for which data show stable prevalence rates except for pockets where use is increasing. SAMHSA's Strategic Prevention Framework (SPF) assures that mental health is part of the approach to suicide prevention; the two issues share risk factors. SAMHSA also is addressing problems of addiction to prescription pain killers. SAMHSA has contributed to two national policy academies and funded fifteen Co-occurring State Incentive Grants, and the President's proposed FY2006 budget provides for four new grants on co-occurring disorders. Mr. Curie asserted that compared with four or five years ago, assessing and treating co-occurring disorders is more the expectation at the treatment door than an exception.

He observed that the issue of stigma remains alive. Similar to the public's view of cancer 40 years ago, when people did not talk about the disease because of stigma, many people continue to view mental illnesses as something that cannot be addressed. Transformation is making progress when mental illnesses become an ordinary issue in conversation.

Discussion. Ms. Power noted the need to raise the message of hope in sectors beyond mental health. Mr. Curie asserted the need for a multifaceted approach to mental health transformation goals, stating that the Voice Awards offer an opportunity to educate the public. Judge Lerner-Wren suggested planning a Council meeting around the next awards presentation. Dr. Bowers-Stephens asked about HHS plans to sustain the transformation effort. Mr. Curie responded that the Federal Executive Steering Committee and workgroup will keep the 20 agencies engaged. Mr. Curie suggested that Council members consider the transformation action steps in the context of SAMHSA's upcoming reauthorization. Dr. Kelly expressed support for NOMs. Dr. Geller suggested that SAMHSA's anti-stigma work target stigmatizing literature published for preteens, particularly the comic book industry and television shows. Dr. Vergare reiterated the need for attention to CMS and the insurance industry, particularly regarding how people can access care and early interventions, rather than acute crisis care. He asked how the CMHS Council might relate internally to other SAMHSA councils and initiatives to integrate cross-center concepts. Mr. Curie noted that integration at the staff level is now business as usual, but he agreed to discuss ways to bring Councils together for a working session and/or ongoing interaction. Judge Lerner-Wren urged that such an effort involve concrete contributions. To a question from Ms. Randall, Ms. Power explained that SAMHSA's matrix workgroups represent staff across SAMHSA's three centers who watch emerging trends and generate ideas to consider for the next round of program initiatives. She stated her anticipation that the next level of collaboration is increased interagency collaboration on grants.

NATIONAL ADVISORY COUNCIL VACANCIES

Ms. Power solicited suggestions for candidates for the two vacancies on the CMHS Council.

OVERVIEW OF GUIDED DISCUSSIONS FORMAT

Dianne McSwain, M.S.W., National Advisory Council Executive Secretary, introduced the format for the meeting's guided discussions, whereby experts were to present issues within a specific topic and set the context for discussion of specific questions.

SUICIDE PREVENTION: GUIDED DISCUSSION

Participants included presenter Dr. Richard McKeon, Special Advisor on Youth Prevention, CMHS, and discussants Dr. Denise Middlebrook, Dr. Crystal Blyler, Pat Shea, and Brenda Bruun. Dr. McKeon presented data showing that suicide is the leading cause of violent deaths worldwide, with 1 million suicide deaths annually. In the United States in 2002, 31,000 suicides across the life span were completed, mostly among older adults. As the baby boom generation ages, a significant increase is possible, an important area for attention. Centers for Disease Control (CDC) data for hospital admissions show approximately 152,000 admissions and 700,000 hospital emergency room visits related to suicide threats and attempts annually. The National Strategy for Suicide Prevention (NSSP) serves as a blueprint for communities and all levels of government. A national priority and public/private partnerships are needed to impact suicide rates significantly. The NSSP addresses issues such as training in suicide prevention for mental health and primary care providers. The Federal Action Agenda provides for forming a national level public/private partnership to advance the NSSP's goals and objectives.

Dr. McKeon asserted that a broad-based public health approach is best for suicide prevention. A lack of continuity is evident between release from the emergency room after a suicide attempt and entering outpatient treatment. Although the period following discharge is one of the highest risk times for suicide, limited information and few model programs exist regarding what happens to at-risk individuals post-discharge. Difficulty in gaining access to care following calls to crisis centers is problematic for people most at risk for suicide. Populations most at risk include rural states, particularly the Intermountain West; rural areas of states; youth involved with the juvenile justice system; American Indian/Alaska Natives, particularly youth; and gay/lesbian/bisexual/ transsexual (GLBT) youth.

By the end of FY2005, SAMHSA will have 44 suicide prevention grantees. As part of the Garrett Lee Smith Initiative, each grantee will conduct a self-evaluation; SAMHSA will fund a national cross-site evaluation; and CMHS and CDC will undertake an enhanced evaluation of three state or tribal sites.

Dr. McKeon stated the discussion questions and asked for feedback on these and other issues:

1. How can SAMHSA best work towards assuring that suicide prevention receives the attention and degree of national priority it deserves?
2. How can a national public/private action alliance best be structured to coordinate implementation of the NSSP, and who would be essential partners in such an alliance?
3. How can we best assure that those at risk for suicide in rural areas, which have the nation's highest rate of suicide, have access to suicide prevention resources?

4. How can we best enhance suicide prevention efforts for at-risk groups, such as the juvenile justice population, American Indian/Alaska Native youth, and GLBT youth?

Discussion. Council members and CMHS staff made the following points: Primary care provider training. Dr. Ida noted that of persons age 65 and older who had attempted or completed suicides, 40 percent had seen a physician in the prior 30 day. She and Dr. Vergare identified the need to train primary care providers in screening. Dr. Vergare noted that training needs to start at the medical school level. He pointed out that suicide detection/prevention is an example of a broader context of issues related to transformation and recovery. Dr. Van Stone urged enlisting primary care providers in the planning process regarding suicide prevention. Dr. McKeon stated that the NSSP attends to the need for primary care screening and training.

- Peer support. Mr. Fricks cited his personal life-changing experience resulting from positive contacts with peers. He urged more attention to promoting peers working with peers to foster regaining hope and learning that recovery is possible. He noted that curriculum development is underway for a peer-to-peer training program on trauma. Dr. McKeon stated that SAMHSA will support the first national conference with a focus on suicide attempters, including self-help, and that he will report on the event to Council.
- Stigma. Judge Lerner-Wren identified a broad reluctance in society to discuss suicide, in part because of fear of self-fulfilling prophecies. She urged attention to developing models for more authentic conversations, such as nonthreatening ways for parents to talk about suicide with their children.
- Risk factors. Dr. Geller noted that although questions 3 and 4 address intervention strategies, the problem is not yet defined adequately with data. Poverty or alcoholism may be important variables. Dr. Vergare suggested that availability of guns may be a factor.
- At-risk groups
  - Dr. Van Stone cautioned against ageism, noting that elderly white males experience the highest rate of suicide. He stated that in the VA health system, those with a recent diagnosis and who have lost a spouse have the highest rates. He noted that depression is not a normal part of aging, but that society discounts suicide among this population.
  - Persons with serious mental illness. Dr. Blyler noted that 90 percent of people who commit suicide have a diagnosable mental illness at time of death. Steps to improve outcomes in serious mental illness are the same actions to take in suicide prevention. A recent *JAMA* article shows that cognitive-behavioral therapy (CBT) decreases suicide. Dr. Vergare stated that CBT is a good intervention following a visit to a crisis center.
  - Ethnic minorities. Dr. Ida noted that contributing factors in rural areas are isolation and language difficulties. She urged translating materials into appropriate languages for such groups as Native Hawaiian and other Pacific Islanders.
  - Victims of interpersonal violence or sexual assault. Dr. McKeon stated that girls who have attempted suicide should be screened for dating violence or sexual assault and that persons who have experienced interpersonal violence should be screened for suicide risk.
  - Child welfare and foster care. Judge Lerner-Wren urged linking a focus on the juvenile justice system with the child welfare and foster care systems. Ms. Shea noted that risk factors overlap and that more juvenile justice exposure produces higher rates of suicide. Good opportunities exist for prevention and early intervention.
  - American Indians. Dr. Middlebrook stated that differences exist in suicide patterns between American Indians and other populations. For example, the method of choice in

Indian Country is primarily hanging, not firearms, and a pattern of clusters emerges in small communities where everyone is related. In Standing Rock, at least 12 young people have committed suicide since December 2005, mostly women. Considerable research has been conducted on the incidence and prevalence of related psychiatric disorder, but she suggested a new direction—historical trauma related to suicide. Ms. Randall stated that American Indians view suicide as a major loss to small Native communities overall.

- CMHS direction. Dr. Vergare urged proper funding for initiatives in the areas mentioned and asked for a synopsis of funding for suicide prevention. He identified the need to link suicide prevention with elimination of bullying and other negative social pressures. Ms. Power concurred with Judge Lerner-Wren's observation on the need to develop strategies to address the multiple factors of suicide, and Dr. Ida identified the need to develop strategies to target specific communities with tailored messages. Dr. Vergare pointed out the challenge of linking this dialogue to ensuing FY2006 grant reviews. Ms. Randall urged initiatives to include prevention components that engage youth in peer-to-peer and community models. Dr. McKeon stated that consensus exists that suicide prevention must take place across a broad continuum with more attention to upstream interventions. Collaboration is needed between suicide and other prevention efforts, including substance abuse.
- National Network for Child Traumatic Stress. Brenda Bruun reported that the network has issued a publication for clinicians that describes risk assessment for suicide and treatment intervention guidelines. Judge Lerner-Wren suggested looking at existing opportunities for SAMHSA to strengthen and promote this agenda.
- Partnerships. Dr. Geller identified the need for incentives for prevention activities that do not stigmatize suicide among private insurers. Dr. McKeon acknowledged the challenge of communicating the suicide prevention message and stated that the Suicide Prevention Resource Center is pursuing private sector-links and working on research to demonstrate suicide's economic and human costs to states and businesses. Dr. Geller suggested enlisting as partners American colleges and universities. Dr. Vergare encouraged engaging business groups, which influence insurance products, and devising strategies to pursue the initiatives. Mr. Fricks suggested approaching Jamie Fuqua, who funds a peer program on late-life depression at Emory University. Dr. Van Stone suggested enlisting collaboration on a peer-group model from the National Rifle Association, Disabled American Veterans, and World War II veterans, and a community approach that enlists meter readers as supports for older adults. Ms. Power stated that CMHS is learning about the Department of Agriculture's Rural Extension Service's resources. Dr. McKeon noted that an Air Force study that communicated that suicide is not acceptable and that asking for help was sign of strength showed a decrease in suicide, accidental deaths, and moderate and severe instances of domestic violence. Ms. Power noted that she will obtain copies for Council members of an effective Marine Corps video that shows how to talk about suicide at the "grunt" level. Dr. Van Stone expressed concern about returning reservists from Iraq and Afghanistan with no support system and suggested enlisting the Reserves and National Guard through their organizations. Dr. Vergare suggested contact with the bartenders' association. Dr. Middlebrook noted the need for collaborations to develop infrastructure to combat poverty. She suggested links with the Departments of Labor and Transportation and agencies and private foundations that focus on community development. Ms. McSwain suggested overtures to the National World Funders Collaborative, a group of foundations interested in rural community development.

- Human and economic costs. Dr. Geller noted that, from industry's point of view, in addition to such ripple effects of suicide on families as subsequent losses in work time and funerals, the issue exists of disproportionate lawsuits. Dr. Blyler questioned a cost-saving rationale of suicide as a benefit to companies, asking what arguments are made in the physical health care world, in terms of equivalent cost savings, about why one should prevent any kind of death. Discrimination is evident in the view that suicide is an acceptable outcome of serious mental illness or old age.
- Collateral deaths. Judge Lerner-Wren noted that industry is willing to address the issue of workplace murder/suicide, about which, Dr. McKeon noted, that new data is emerging on frequency and context. Dr. Geller suggested attention to suicide and unintended homicide, cop suicides, and unintended accidents.
- Judge Lerner-Wren suggested elevating suicide prevention beyond matrix priorities and cross-cutting principles to foster integrated attention by multiple agencies. Ms. Power noted that Congress is in fact signaling elevation of the issue through passage of the Garrett Lee Smith Act and other factors.

PUBLIC COMMENT

Kathy Muscari, Director, Consumer Organization and Networking Technical Assistance Center (CONTAC), stated that clinicians and social workers who detect suicide risk are trained to go into proactive mode, which can entail foregoing confidentiality and dialogue, and result perhaps in admission to the hospital, where many people endure isolation and dwell on their difficulties. She stated that when people say they are thinking about suicide, peers talk to them instead of going into crisis/risk-management mode. Ms. Muscari suggested training clinicians to bridge the gap between professional and peer services; to look for earlier signs of grief, poverty, or teen problems; and possibly to refer people to peer groups. She noted that some peer specialist trainings offer prevention training—who best to counsel than one who made it through?

Louise Peloquin, Ph.D., noted that in her work with John Tuskan and CMHS's Refugee Mental Health Program, she and her colleagues will be informed by the dialogue as they confront the issues of immigrants and refugees within a variety of contexts around suicide prevention.

Dan Fisher, M.D., Commissioner, New Freedom Commission, in echoing the unique importance of the role of peers, described an NIMH-funded, recovery-oriented project called Stepping Stones. The consumer-run program offers warmlines, designed for persons who want to talk with someone before reaching crisis level (research shows a 60 percent reduction in emergency room visits when warmlines are available); recovery centers, each with its own warmline; a restaurant run by people who have recovered; and an overnight respite facility run by people who have recovered or are recovering from mental illness. He urged higher pay scales, creative funding for such operations, and disseminating the model.

Glenn Koons, Pennsylvania, Advocate, described the importance to him personally of peer support and the importance of serving as a peer advocate for suicide prevention.

SERVING THE CHILDREN ACROSS SAMHSA: GUIDED DISCUSSION

Presenters included Sybil Goldman, M.S.W., Senior Advisor on Children, SAMHSA; Randy Muck, Center for Substance Abuse Treatment, SAMHSA; and Susan G. Keys, Ph.D., Branch,

Prevention Initiatives and Priority Programs Development Branch. Ms. Goldman offered an overview of SAMHSA's focused, strategic, and broadly collaborative work on children's issues. Children and families span many systems, and on SAMHSA's Matrix of Program Priorities, children and families are a crosscut of every priority. NOMs, which are relevant for children, will be used across all grants and activities. A SAMHSA matrix workgroup that convenes policy and program staff works to improve outcomes for children with or at risk for mental and/or substance use disorders and their families by increasing access to a continuum of comprehensive, integrated, quality services and supports that include prevention, early intervention, and treatment. Principles that guide the group include a child developmental focus; understanding of children as part of families; continuum of prevention, early intervention, and treatment in a public health context that addresses risk and protective factors; family-driven and youth-guided services and supports for children, adolescents, and their families; culturally and linguistically competent; individualized and strengths-based and community-based approach; and mental health and substance abuse services that are comprehensive, coordinated, and integrated across multiple service systems. Action Agenda strategies include participation in the SPF, mental health transformation, closing the substance abuse treatment gap, and co-occurring disorders; increasing investment in improving service capacity; building infrastructure at the state and community levels; aligning federal programs, improving effectiveness and sustainability of programs, and increasing accountability.

Ms. Goldman stated that the workgroups collaborate across centers, for example, in efforts to integrate technical assistance efforts for grantees. A document is in development to provide incentives for primary care physicians to look at mental health and substance abuse needs of young children and parents. SAMHSA is developing a financing guide for braiding multiple funding streams and also has issued a paper that sets science-based screening in context as background for an upcoming compendium of screening tools with reliability and validity for various age groups. SAMHSA also proposes to conduct a forum for community coalitions and family organizations on mental health and substance.

Mr. Muck stated that among youth entering CSAT-funded treatment, 60-70 percent have co-occurring mental health disorders, which has prompted collaboration with CMHS. CMHS and CSAT initially convened grantees in Systems of Care and Strengthening Communities Youth, respectively, in several formats to foster community collaboration. Both agencies share funding for the current Children and Adolescent State Incentive Grant program geared toward youth and children with mental health, substance abuse, or co-occurring disorders. The National Child Traumatic Stress Initiative recently has sought collaboration from CSAT; CSAT is discussing a curriculum for treatment for substance abuse and trauma for youth with Boston University; and CMHS's juvenile justice policy academies now include a substance abuse focus. An interagency agreement with the Department of Justice's Office of Juvenile Justice and Delinquency Prevention provides $100,000 to CSAT to work on co-occurring disorders among youth in a program that includes prevention. CSAT has provided technical assistance to mental health agencies about youth with co-occurring disorders, and recently several mental health programs have won CSAT grants to infuse substance abuse treatment into mental health programs. CSAT has participated with other organizations in conferences on co-occurring disorders among adolescents. All CSAT programs now require or strongly encourage use of a specific screening

tool for mental health disorders as participants enter. CSAT now is grappling with providing integrated services and developing models, since few models have been validated empirically.

Ms. Goldman stated that the National Registry of Effective Programs and Practices has expanded beyond prevention to include evidence-based treatment for mental health problems, substance abuse, and co-occurring disorders. She highlighted SAMHSA's work with other federal agencies that includes joint planning and action, co-funded grants, work with NIH institutes, collaborative training and technical assistance, and information exchange. SAMHSA is creating a compendium of such activities to foster strategic thinking and priority setting. SAMHSA participates in major initiatives created or mandated by the White House and Congress that involve, for example, mid-teenagers, autism, American Indians, and synthetic drugs. SAMHSA has spearheaded a Federal National Partnership for Transforming Child & Family Mental Health and Substance Abuse Prevention and Treatment to implement action steps for children and families in the Action Agenda. SAMHSA co-funds grants with other HHS agencies and other departments on bridging science to services, youth violence prevention, workforce issues, technical assistance, reducing underage alcohol use, and others.

Dr. Keys focused on schools as a major SAMHSA partner. She explained that few children with mental health needs have access to services and that schools play a critical role in the service delivery system. CMHS is seeking to expand the traditional vision of school-based models, which address students most in need, to incorporate also a public health, population-based approach to school-centered services that includes prevention, education, empowerment, and advocacy; addresses risk and protective factors in and out of schools; develops knowledge and skills related to social competence for students, teachers, and parents; engages family members as decision makers; uses contacts with elected officials and other leaders to affect policy changes; and incorporates interventions across systems that address the broader context. Dr. Keys described the components of prevention: universal, delivered to all children and youth, including mental health promotion as part of overall health; selective intervention, geared to the 15 percent of children who have certain risk factors and require a more targeted intervention; and indicated, for the 5 percent of children who need more concentrated interventions and in some cases have diagnoses and need treatment. She asserted that school-based mental health programs need multiple levels of interventions at all grade levels for students at risk, who experience significant problems, and/or have diagnoses, and also for their significant adults, in addition to attention to the context of school climate and organization and community. Dr. Keys noted that CMHS is sponsoring a series of broad-based stakeholder dialogues to expand the conceptual framework of school-based mental health services.

Ms. Goldman posed the following questions and asked for feedback:
1. What collaborations would you like to see happen internally across SAMHSA's centers?
2. What collaborations would you like to see happen that involve other federal agencies?

Discussion. Council members and CMHS staff made the following points:

- Dr. Vergare echoed the need to link behavioral with general health care services. He noted the interplay of housing, citing the critical need for respite and other appropriate environments for kids. He also highlighted the problem of limited access to high-level professional services and evaluation. Ms. Goldman identified the tension of taking

resources from a residential and inpatient system to build a community-based system. Dr. Vergare suggested the need for more data about the problem.

- Dr. Geller identified the need for payers to reimburse for collaborative professional contacts. Ms. Goldman described efforts to foster partnerships with Medicaid, noting that insufficient work has been done with private-sector payers, who do not understand what service delivery systems should look like for children and youth. She noted that financing often is provided by educational, child welfare, and/or juvenile justice systems.
- To Dr. Geller's question about collaboration on co-occurring developmental disorders, Ms. Goldman noted that HHS convened a summit of federal agencies. An action plan to close the gaps has been developed and an effective state model is being developed.
- Dr. Ida urged attention to workforce training that is developmentally, linguistically, and culturally competent to avoid misdiagnosis. Ms. Goldman stated that the Annapolis Coalition can help with that issue, and SAMHSA is working across federal agencies to encourage funding to accomplish this objective. Dr. Ida noted that silos interfere with cross-training and that retraining funds must be designated with specificity.
- Dr. Bowers-Stephens noted the importance of blending funding streams for integrated early childhood intervention and prevention. Ms. Goldman stated that a workgroup involving the Health Resources and Services Administration, Administration for Children and Families, and the Department of Education is undertaking this work. In addition the Action Agenda calls for development of a national plan for how to improve agencies programs for young children.

PARTNERS IN RECOVERY: GUIDED DISCUSSION

Presenters included Carole Schauer, R.N., Senior Consumer Affairs Specialist, and Chris Marshall, Consumer Affairs Specialist, CMHS. Ms. Schauer noted that the consumer affairs staff works to ensure consumer-driven and consumer-operated approaches to transform mental health systems and to achieve recovery and community integration with meaningful choices about treatment options and providers. The Action Agenda calls for the development of a prototype individualized plan of care to promote resilience and recovery, and a national public education campaign to improve general understanding of mental health problems.

Ms. Schauer described consumer participation in partnership with CMHS in selected programs and activities and how recovery and individual plans of care are addressed. To define recovery SAMHSA and the Interagency Committee on Disability Research convened a national consensus conference, the results of which will be published soon. A definition of family-driven care has been written, and a consensus meeting on individual plans of care will be held. The current working definition for consumer is an individual who has used or is using mental health services, or who self-identifies as a consumer. Ms. Schauer reported that CMHS has sponsored primary care and criminal justice dialogue meetings, and an upcoming dialogue will focus on youth. Each dialogue results in a series of recommendations to develop partnerships and publication of a meeting summary. "Free to Choose: Transforming Behavioral Health Care to Self-Direction" reports on the 2004 Consumer Direction Initiative Summit. Nineteen organizations have received statewide networking grants to strengthen networks; develop skills, particularly in managing businesses; and focus on leadership. CMHS funds five consumer and consumer-supported technical assistance centers that provide training and support to consumer-run organizations. More than 600 consumers will attend the CMHS-supported Alternatives conference in October.

Consumers and family members sit on CMHS review panels for grants, and a number of requirements for the Mental Health SIG relate to consumer and family involvement.

Mr. Marshall described selected CMHS's activities to counter stigma and discrimination. At a 2001 CMHS meeting 200 diverse experts reviewed research findings and best practices, and recommended initiating a national campaign against discrimination and stigma. The eight-state Eliminating Barriers Initiative (EBI) targeted the general public, teachers and school administrators, and business human resource managers, and convened state workgroups of consumers and other stakeholders who offered input on evidence-based materials with recovery and strengths-based themes. The initiative's pilot public service announcements drew an audience of 221.5 million people. From this activity emerged the recent Voice Awards. EBI, which currently is completing an evaluation and preparing a toolkit, has helped produce an evidence base to inform the national anti-stigma campaign. Research has shown that stigma has worsened; fear is a big contributor; people want to be compassionate and are shocked to learn that people can recover; and a campaign should encompass a recovery theme, strengths-based approach, and a normalizing message. The message of the strategy under development is that recovery is possible; treatment works; get information and seek help if you need it. CMHS has developed a peer support resource kit to help states, consumers, and other stakeholders to increase skills and knowledge on building peer-support programs.

Ms. Schauer posed the following questions and asked for feedback:

1. The President's Commission, the Institute of Medicine, the Federal Action Agenda, and many others have called for consumer-driven strategies to transform mental health and overall health care. How can CMHS build on its existing work in this area?
2. Self-care strategies, including consumer health literacy, are promising strategies to foster recovery. How can we do a better job of educating Americans with mental health problems so that they can better manage their own mental health problems?
3. Due in part to stigma, people with mental illnesses have not been fully engaged as partners in recovery. How can we better educate program administrators, researchers, providers, family members, and consumers to recognize the value of consumer participation?
4. Self-directed approaches have been adopted successfully in various disability communities. How can CMHS further explore these approaches and test their feasibility in mental health care?

Discussion. Council members and CMHS staff made the following points:

- Dr. Bowers-Stephens urged federal attention to individual service plans, guided by the experience of the developmental disability community and the work of Dr. Neal Adams.
- Ms. Power urged Council members to participate in CMHS activities mentioned. She suggested creating a master calendar of events and invited members to inform Ms. McSwain or Ms. Schauer of their particular interests.
- In response to a question from Judge Lerner-Wren about the evidence base and consumer-related definitions, the presenters explained that *self-directed care* refers to a program model that falls under the definition of self-determination. CMHS is adapting the model that originated in the developmental and physical disability communities. *Consumer-driven care* refers to consumers and families driving their health care. The Subcommittee on Consumer/Survivor Issues is developing an operational definition for

consumer driven. Ms. Power noted that language issues are developmental and that CMHS is learning from other disciplines. She noted that NOMs include employment, just one way to measure the extent of recovery.

- Dr. Geller raised a sensitive issue by commenting that focusing on a term such as *consumer* stigmatizes people with mental illnesses; no one should be a consumer first, but rather a person who is a consumer. He acknowledged that use of the term is evolutionary. Judge Lerner-Wren spoke to the political relevance of consumers having a specific, identified voice. Mr. Fricks explained the need for an identity to be able to challenge the status quo, stigma, and false beliefs, and asserted that an identity to consumers has been important. He highlighted as an example the powerful movement in which consumers in 18 states lead efforts to restore cemeteries where mental patients once were buried anonymously. Dr. Ida commented that the response to the term *consumer* is important, not the self-identification itself. Dr. Vergare concurred in consideration of the term as evolutionary and urged thought about how to move forward. Dr. Geller stated that his concern is the focus on the term *consumer* as an endpoint rather than as a process.
- Dr. Van Stone commented that people who have recovered from mental illnesses are invisible—just like anyone else—and people who obviously have mental problems clearly have not recovered. He noted the hard sell in identifying with *recovery* as long as people who are untreated are on the streets. Part of the problem is to address the people who do not receive treatment who are on the streets. Ms. Power responded that that position is being tested in the national anti-stigma campaign.
- Dr. Ida asserted the importance of training providers to establish culturally competent rapport with consumers—a shift to "nothing about us without us."
- Dr. Vergare commended the activities that promulgate the message that diverse mental illnesses are treatable. Nevertheless, consumers encounter barriers to access care; he asserted that insurance and other payer barriers impede access early in life and/or early in the trajectory of illness and therefore impede recovery. He reiterated the need to address the stigma problem around co-payments and other restrictions. He stated that when messages are repeated about people getting treatment and getting better, other people will want treatment; what might today be considered boutique becomes the norm, as is happening with post-partum depression since celebrities have raised the issue. Ms. Schauer noted that lessons may be learned from HIV/AIDS regarding stigma. Dr. Geller suggested a more proactive agenda to combat potentially stigmatizing events. Mr. Marshall noted that CMHS partners with the Carter Center's Mental Health Journalism Program in the national anti-stigma campaign.

REPORT OF THE CONSUMER SUBCOMMITTEE

Larry Fricks, Chair, Subcommittee on Consumer/Survivor Issues, CMHS National Advisory Council, identified new Subcommittee members Ellen Awai of Hawaii, a certified peer specialist, and Carlette Randall, M.S.W. He reported on the proceedings of the Subcommittee's August 15-16, 2005, meeting, at which the CMHS-funded technical assistance centers described their work. The Subcommittee has embraced the task of deriving a national definition of *consumer driven.* Kansas's consumer affairs director spoke about its successful process, and Subcommittee members took initial steps in devising a strategy to disseminate a draft definition.

Mr. Fricks stated that the CMHS National Advisory Council Subcommittee on Consumer/ Survivor Issues recommends that the CMHS National Advisory Council advise CMHS to:

1. Support the dissemination of the Subcommittee consensus definition for "consumer-driven" as referenced in *Transforming Mental Health Care in America: The Federal Action Agenda* so that the definition will roll out and serve in tandem with the SAMHSA/CMHS-supported consensus definition of "recovery."
2. Ensure that all recipients of CMHS grants and contracts are incorporating the values, principles, and stated goals of mental health transformation into their own organizations by requiring that all recipients of CMHS grants and contracts have mental health consumers as members of their governing bodies and that these recipients employ and integrate consumers into their workplace.
3. Support consumer-driven transformation operationally with the Federal Partners Senior Workgroup and the Federal Executive Steering Committee by developing an action step that requires the Federal Partners and the Steering Committee to appoint mental health consumer advisors on all of their respective agencies' advisory councils and boards.

Regarding the first recommendation, Ms. Power stated that she will address the issue administratively. The consensus definition of *recovery* has been approved and will be disseminated imminently. When the definition of *consumer driven* is complete, it too will be released. Regarding the second recommendation, Ms. Power stated that she will continue to give guidance to CMHS grants and contracts to incorporate the values, principles, and stated goals of mental health transformation in their organizations. She noted that she can encourage adding mental health consumers to the workforce, but cannot require it. Ms. Power pledged to bring the Subcommittee's third recommendation to the federal partners. In summary, the Council addressed the Subcommittee's recommendations by consensus.

COUNCIL DISCUSSION

Dr. Vergare noted that the film *Inside/Outside* is a useful teaching tool. He suggested producing additional films with other community experiences. Ms. Power stated that CMHS has commissioned a short version of *Out of the Shadows* also as a teaching tool. She suggested that EBI produce profiles and stories to use similarly. Dr. Ida noted that a young filmmaker intends to look at mental health among Asian American and Hawaiian and Pacific Islander populations. She suggested a series that addresses diverse populations, including GLBT and children. Dr. Geller suggested the power of being able to state, even without attribution, that a certain percentage of Council members self-identify as mental health consumers.

PUBLIC COMMENT

Subcommittee on Consumer/Survivor Issues Ellen Awai described consumer activities in Hawaii, including a certified peer specialist network, NAMI, and a small group of mental health consumer advocates. Hawaiian consumers are particularly concerned about housing, Medicare and Medicaid coverage, and suicide prevention.

Emily Hoffman, On Our Own in Maryland, Baltimore, stated that her organization represents 20 consumer-run organizations in Maryland that offer drop-in center activities. She asserted the importance of consumers combating stigma with their own stories. She also raised the issues of trauma, noting SAMHSA's support to end seclusion and restraint, and of the prevalent notion

among providers in the community of the paramount importance of rehabilitation and maintenance. Ms. Hoffman stated that her organization is addressing self-determination and self-directed care at the state level.

Ramiro Guevara, Director, Star Center, an organization funded by CMHS/SAMHSA focused on helping consumer-operated programs achieve cultural competency, urged attention to ensuring that all messages and materials resonate with people in diverse communities.

Dan Fisher, M.D., Commissioner, New Freedom Commission, asserted that distinctions are based on stigma; as stigma is removed, the need lessens to self-identify as mental health consumers. He emphasized the need to self-identify and to share personal stories to help remove stigma. He urged CMHS to refer to *consumer driven* instead of *consumer centered.* He suggested a definition for *consumer driven:* "when the participation of consumers makes a difference towards recovery, transformation in training, policy formation, and research and service delivery." The major thrust would be to establish scales and qualitative evaluations, with statements of participants about whether a program or activity made a personal difference based on outcome. He noted the need to accumulate evidence that consumers have made a difference. He also asserted the need to encourage consumers' genuine participation, something that he credits CMHS with doing.

Adjournment. The meeting recessed at 5:00 p.m., and Council members reconvened the following morning in open session.

August 19, 2005

Ms. Power called the meeting to order at 8:55 a.m. and introduced CMHS's "Transformation Trends" information series. Mr. Fricks commented that the management team in his state office uses the documents and urged continuing publication. Ms. Power stated that feedback on what is happening in the field would be useful to track transformation. She said that she received an e-mail from Dr. Everett with a list of possible activities in which to engage with the Council. Ms. Power will follow up on the Council's request for an "overlap day" with SAMHSA's Council and invited members to the Voice Awards in July 2006, if awards are held, but noted that a grant review meeting still may be required in August.

TRANSFORMATION: NATIONAL ADVISORY COUNCIL DISCUSSION

Ms. Power asked Council members to consider the following questions:

1. What issues at the local, state, and national levels do you see as fundamental to achieve transformation? From your perspective on where you see CMHS and the field going, what are you observing out in the world, and where are the spheres and scope of influence you think we should be attending to or that you have an interest in?
2. What are your personal and professional experiences in which you have witnessed transformation in action? What is going on that would be helpful for us to know about and that we can learn from?
3. What else can the federal partners do to effect change that moves beyond working trust and partnership?
4. What methods of reaching individual consumers and families would be effective?

Council members made the following points:

- Dr. Geller noted that transformation has not reached professional students or trainees. Residents are largely uninformed or ill-informed; residents have no time to think about systems. Transformation has not reached academia, especially among researchers or general hospital psychiatrists who function outside the public sector. He believes that in an evolutionary process, the first step has been achieved of getting leadership and consumers/users in the public sector to embrace the concept. It remains a larger challenge to reach certain sectors of the mental health field in all disciplines that resist transformation. For example, American Psychiatric Association board did not support the APA Assembly's vote to end the IMD exclusion because of possible ramifications for general hospital psychiatry. Ms. Power asserted that it will be CMHS and Council's task to determine how to move transformation forward and identify influences that resist transformation. Dr. Geller described strong resistance to a cost-saving advocacy project proposed by residents for a reimbursement code for mutual consultation between the psychiatrist and primary care physician of individuals who have serious mental illnesses.
- Mr. Fricks identified four factors as transformative: (1) In training certified peer specialists, it is critical to train supervisors and management of the traditional system. Supervisors must learn to understand strengths-based recovery, steps in the recovery process, and the role of peer specialists as transformation agents. Front-end investment in supervisor and staff training is essential to avert worry over job losses and job changes. (2) Working with the Medical College of Georgia has created a partnership with the state system that has elevated transformation and put the peer-specialist initiative on the governor's radar. To secure buy-in, residents help design their training. (3) Funding has been made available to introduce all Georgia's regional and upper management to transformation at a major event at the Carter Center that will feature mental health luminaries. (4) Despite cautions by clinicians, peer specialists are learning to deal safely with trauma and will bill Medicaid for their training (not consulting) services to peers. Mr. Fricks observed the importance of sustainable income. He stated that peer support did not take off until it was possible to bill for it, but now it is the fastest growing rehabilitation service in Georgia.
- Dr. Kelly described the situation in California: (1) Passage of Proposition 63 generated $750 million in new dollars to use for mental health services annually. State mental health director Steve Mayberg sets the vision for the state to use new money to support only new transformational services, but the message has not trickled down, for example, to training programs in psychology for either faculty or students. He suggested sending the message to various disciplines through organizations that work with them, such as the National Council for School and Psychology Programs and CUDCUP (for Ph.D. training programs). (2) Dr. Kelly is working to help create a juvenile mental health court using Prop 63 funds, but the project has met with resistance despite the ability of such a court to move away from incarceration and toward more effective and compassionate, and less expensive, services. Certain bureaucrats rename pet projects and declare them to be transformative, making it difficult to move beyond the status quo. He stated that Los Angeles County's Department of Mental Health provided no guidance on types of projects that would be transformative and no training on the change process. He suggested that the state would benefit from more specific guidance and recommendations

from the national level and the state's Department of Mental Health about specific services, treatments, and programs that would transform the system.

- In continued discussion of training issues, Dr. Vergare identified fears among community systems about whether paying peer counselors might result in slashed budgets for social workers. He noted the similarity to dynamics involved in closing hospitals; the most difficult issues centered on unions and personnel. He stated his expectation that each state will approach the issue differently. Dr. Vergare asserted that transformation has no meaning in his own system, although what his residents and staff would want to have available for their patients is consistent with Council's view. He explained that following stabilization of patients, his residents are frustrated because no resources are available for patients in the community upon discharge. Community systems, with more limited resources, will be more conservative about making changes. In terms of building career paths, Dr. Vergare observed that residents do not see a future in community centers to interact with primary care or participate in multidisciplinary teams; they would be hired to write prescriptions. He suggested that the Annapolis Coalition be asked to look at how systems can build career paths to coincide with emerging factors for good care. Although the RRC dictates resident training, each program has its own personality driven mostly where it resides, how it is funded locally, and how its faculty is funded. Dr. Vergare noted that Pennsylvania does not fund activities that connect with the training of psychiatrists, psychologists, or social workers, and a large gap exists in downsizing and closing institutions and then moving the funds into communities. Although good things are happening in the state, he observed, there is no connection between those and the way the state would support education, a critical issue in sustaining efforts. He suggested revisiting in the context of transformation a problem that exists with the Public Health Service's loan forgiveness program for trainees in underserved areas. Often residents who want to stay in the urban environment cannot do so because no vacancies have occurred in that program in years. On the positive side, Dr. Vergare noted that the American Psychiatric Association rapidly approved a position statement on recovery, which demonstrates a degree of buy-in despite the fact that the term *recovery* does not appear in the statement. He stated that he will involve himself in the residency review process, including working on how to mandate research in every residency program.
- Dr. Ida emphasized the importance of the workforce issue and her hope that the Annapolis Coalition's efforts will produce a template with teeth to break through resistance in the field. She stated that CMHS's Reducing Disparities Workforce Training Grants grantees will discuss results regarding curricula and outcomes. She noted that early clinical psychologist training did not consider systems issues. Cultural competency is moving slowly in positive directions by bringing diverse populations into the workforce, training the entire workforce on cultural competency issues, and bringing in translators when necessary. In her experience agencies enjoyed doing the training, but the need exists for increased Congressional appropriations to fund training. She reported that New Jersey has passed legislation mandating cultural competencies for licensure.
- Dr. Bowers-Stephens offered three recommendations. (1) Develop an operational definition for transformation, prior to release of the Mental Health SIG grants so grantees will understand the expectations, and making available objective measures of the transformation process. NOMs will describe clinical outcomes, but process outcomes are needed to keep the process alive. She compared this effort to the Children's Mental

Health Initiative, which was pushed to report outcomes that produced momentum. She offered her assistance in deriving the definition. (2) Provide technical assistance, such as policy academies, on transformation and change management to change agents in state, educational, and other entities, to engage governors and other major stakeholders. (3) Use existing healthy tensions within state mental health departments between the block grant and comprehensive mental health plans to transform the block grant. She urged providing guidance to set boundaries around the tension in order to avoid divisiveness and to push the change. Dr. Bowers-Stephens explained that Louisiana has incorporated the transformation concept into an ongoing reform process in juvenile justice and health care, a process successful because the governor convened a state leadership workgroup to guide the transformation process. Dr. Bowers-Stephens integrated the New Freedom Commission goals and objectives with the governor's health care plan, distributed it, and talked about it. She encouraged thinking outside the mental health box. She anticipated that the greatest challenge will be to engage nonprofits, the private sector, and education, but that the first step is to get one's house in order with state and federal entities for support, sustainability, and buy-in. Ms. Power stated that CMHS will learn from transformation implementation experiences in the field. Currently staff is reviewing all SIG applications to glean applicants' views of transformation and to identify process outcomes. She suggested that Dr. Bowers-Stephens discuss the block grant and comprehensive planning process with NASMHPD.

- Dr. Van Stone described the VA's active involvement in transformation, which includes its own action agenda, strong agency leadership, well-supported mental health strategic plan, and funding of $60 million in FY2005 and $100 million in FY2006 for supported employment and communication about recovery. He noted that the VA transformed in the mid-1990s from a hospital-based specialty system to a community-based primary care system that feeds to its hospitals. The VA plans to work in an unprecedented way with each state to develop a mental health plan that incorporates the VA into state programs. In addition, Dr. Van Stone stated that half the nation's health professionals are trained in the VA system, which is affiliated with 103 medical schools. He asserted that as residents, interns, social workers, and nurses are exposed to transformation concepts in the VA, they may be motivated to implement what they learned in their eventual affiliations. Dr. Van Stone pointed out that the VA's successful electronic medical records system may motivate trainees to export it eventually to their own private "nonsystems." He recommended investigating how to use the VA as a vehicle to help transform states and other systems.
- Dr. Geller posed several questions: Can the federal government take the lead in changing states' public mental health systems absent class action suits in federal courts? Has a preconceived national policy in public mental health resulted in intended consequences (he noted that deinstitutionalization was neither a state nor a national policy)? Can transformation take place in a system in which payment sources are overwhelmingly determined by locus of service? To make his point, he noted ironically that the best fiscal scenario for state governors and taxpayers would be for people whose mental health problems are not too serious to be in the community, all those who were ill in jail, and no one in the state hospital. He asserted that transformation requires a system that provides services where people appear for services without shifting costs to the federal government. In response to Dr. Geller's first question, Dr. Bowers-Stephens stated that

federal funding silos and the expectation that states must bundle the silos to develop a system represent one of the greatest barriers to transforming states at the local level and to obtaining sustainable funding. She asserted that bundling funds prior to distribution to the states would aid in the transformative process, and that advocacy for developing legislative change is needed to support the transformation process. Using service provision to support families with children under age five as an example, she stated that funds should be bundled before distribution to states to provide early intervention, prevention, and a public health approach to mental health. The current fragmented system duplicates resources and shrinks funds for service delivery. Dr. Kelly observed that Mike Hogan has preached that position for years and that, in his own experience as Virginia's commissioner, excessive time and money are spent deciding how to deploy resources. He suggested attention to demonstrating to policy makers that transforming public policy in positive directions also benefits the bottom line.

- Dr. Vergare observed the value of funding demonstration projects known to show financial savings and better redirect people to transformed care. Dr. Bowers-Stephens cautioned that demonstration projects typically are not sustained. Dr. Ida urged federal bundling of funds combined with the requirement for collaboration at the state level to use the funds. Dr. Geller concurred that policy makers often use findings from demonstration projects selectively. Dr. Kelly noted that California's Prop 63 funds are sustainable. Dr. Van Stone asked whether studies have focused on whether demonstration projects have impacts beyond the demonstration. Dr. Vergare pointed out that the VA system of electronic patient records probably once was a demonstration project and that, in the private sector, the VA's record system works de facto as a demonstration project.
- Dr. Geller suggested a federal mandate for VA hospitals to establish relationships at the local level with the closest state hospital to coordinate care, a practice that would have positive fiscal consequences. Dr. Van Stone stated that he will follow up on that idea.

Public Comment. Time was set aside for public comment, but no one came forward to speak.

WRAP-UP AND PREPARATION FOR NEXT MEETING

Dianne McSwain, National Advisory Council Executive Secretary, led the closing discussion on the new format for the Council meeting. Dr. Ida expressed appreciation for the in-depth presentations accompanied by Council's opportunity to offer input and feedback on topics of importance to members. Ms. McSwain reported that it was important to staff to have sat at the Council table to talk and listen. Dr. Vergare responded that it is important to Council members to connect with staff meaningfully and legally in an "upstream" context. He stated that he has thought about how to follow up on the discussions—when and how will the discussions and ideas converge in CMHS's portfolio?—and how to track the process. Regarding meeting logistics, more water at meetings would be helpful as would determining the frequency and timing of Council meetings. Ms. McSwain stated that Ms. Power will speak with Mr. Curie about an overlap day with the SAMHSA Council. She asked Council members to inform her about other scheduled meetings through spring 2006 to avoid conflicts. Dr. Kelly expressed appreciation for a format that resulted in a productive, enjoyable, and important meeting. Council members applauded Ms. McSwain's contribution to the meeting. Dr. Kelly urged follow up and maintaining momentum. Dr. Geller requested development of a tracking system to determine the impacts and outcomes of Council discussions. Ms. McSwain stated that she will develop a draft

system and will elicit comment from Council members. Dr. Geller suggested that the minutes can serve as an initial document from which to extract key issues. Dr. Vergare urged earlier distribution of the draft minutes to Council members.

Ms. McSwain noted that future topics will include quality and accountability and a focused session on recovery. In addition, Council members suggested co-occurring substance abuse disorders, co-occurring developmental disability, IMD exclusion, Annapolis Group's work on workforce issues, brainstorming on a draft operational definition of transformation and outcome measures for SIGs, legislative update of issues, update and dialogue on NOMs, an upstream budget discussion, and the interplay between transformation and funding issues from CMS and private insurance. Ms. McSwain invited Council members to submit additional ideas via e-mail. Dr. Kelly suggested that the budget subcommittee might be dissolved. Dr. Vergare requested that CMHS provide Council members with summary budget timelines. Ms. McSwain stated that she will work with SAMHSA's Daryl Kade to arrange the most effective upstream interaction. Dr. Geller raised the issue of transportation difficulties to SAMHSA headquarters for persons who wish to provide public comment. Mr. Searle stated that a free shuttle from the Metro station for employees might be made available to persons who wish to attend Council meetings. Council members discussed their preferences regarding frequency and length of meetings, generally two-day meetings that are more compressed. Dr. Kelly noted that the working lunch is helpful, particularly on the first day. Council members expressed appreciation for contributions by staff and contractors.

Adjournment. Mr. Searle adjourned the Council meeting at 11:05 a.m.

The above minutes for the August 17-19, 2005 meeting of the CMHS National Advisory Council were approved by the Council on March 22, 2006.

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A. Kathryn Power, M.Ed.
Chairperson
Center for Mental Health Services
National Advisory Council